

Business Insurance

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20 insurers file subrogation suit to recover Chicago flood payouts

CHICAGO—Twenty property/casualty insurers filed several suits Friday against the City of Chicago and Great Lakes Dredge & Dock Corp. to recover tens of millions of dollars of property damage and economic losses that policyholders sustained in the city's underground flood last April.

John B. McCabe, an attorney representing 11 insurers, said he expected many more insurers to file separate suits late Friday in an effort to recover up to \$200 million.

Continued on next page

Boycott charge grabs attention of high court

By JUDY GREENWALD

WASHINGTON—Whether insurance industry defendants engaged in a boycott during the mid-1980s may be the key question in the minds of the U.S. Supreme Court justices considering the nearly 5-year-old insurance antitrust litigation.

During oral arguments before the U.S. Supreme Court last week, the justices appeared most interested in whether the actions of the 32 insurance industry defendants constituted a boycott. The antitrust exemptions contained in the McCarran-Ferguson Act do not extend to coercion or boycotts.

After reviewing the justice's questions and comments during Tuesday's arguments, attorneys for both plaintiffs and defendants say it's impossible to predict how the court will rule on any of the three specific issues before it.

A decision is expected no later than early July, when the court ends its current session.

"I have as much trouble as a lot of people reading the tea leaves," said Lisa Tiegel, special

assistant to the Minnesota attorney general, one of the 19 state attorneys general who brought the antitrust charges.

Ms. Tiegel added, however, that she was hopeful the court would side with the states.

"I would say there's a lot of interest shown in the positions we were taking," but there is no way to predict the outcome, said William A. Montgomery, an attorney with Schiff Hardin & Waite in Chicago, who represents defendant Hartford Fire Insurance Co.

The closest any attorney would come to a prediction was John DeQ. Briggs, an attorney with Howrey & Simon in Washington who represents defendant Prudential Reinsurance Co. "It's likely that something will go back to the district court," he said, though he is not sure what issue. "I don't think the Supreme Court will reverse the 9th Circuit in all respects."

The 9th U.S. Circuit Court of Appeals in June 1991 overturned a lower court decision that had dismissed the litigation (*BI*, June 24, 1991).

In the original lawsuits filed

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Group health care inflation slows

While group health care costs neared \$4,000 per employee in 1992, the rate of increase was the lowest in five years. Even so, average health care costs approached \$5,000 per employee in some industries.

High-cost industries

Energy/petroleum
\$4,985

Communications
\$4,913

Utilities
\$4,894

Transportation
\$4,537

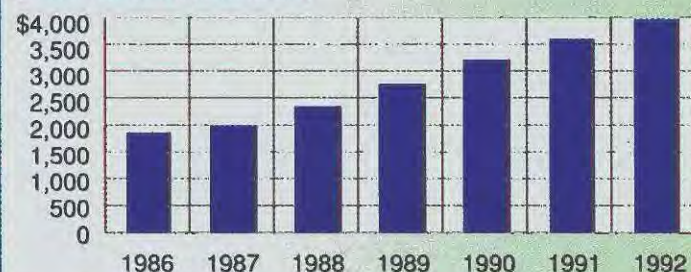
Mining/construction
\$4,263

Manufacturing
\$4,262

*Includes employer and employee contributions for indemnity plans, managed care plans, dental plans and vision/hearing plans

Source: A. Foster Higgins & Co. Inc.

Group health care costs*



Group health care inflation



GRAPHIC BY CHRIS ROY

Health benefit costs rose 'only' 10% in '92

By JERRY GEISEL

Group health care cost increases are continuing to ease, but costs still are rising by double-digit amounts that are more than three times the general inflation rate.

Overall health care benefit costs—including medical indemnity plans, health maintenance organizations, and dental and vision plan costs—climbed 10.1% to \$3,968 per employee on average in 1992 from \$3,605 in 1991, according to a detailed new survey by benefit consultant A. Foster Higgins & Co. Inc.

While big, the rate of increase in 1992 was the lowest in five years. Group health care costs climbed 12.1% in 1991, 17.1% in 1990, 16.7% in 1989 and 18.6% in 1988.

Health care costs last rose by a single-digit percentage five years earlier, when they rose 6.9% to \$1,985 per employee on average in 1987, from \$1,857 in 1986.

The cooling of health care inflation is clearly good news for employers that began thinking in the late 1980s that health care costs had become uncontrollable.

Still, health care cost increases continue to outpace the general inflation rate, which was only 2.9% last year, revealing how much more employers, providers and government must do to control costs.

"Certainly, the 1992 numbers are encouraging. But the problem of high health care inflation remains," said John Erb, a principal in Foster Higgins & Co. Inc.

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Bel-Aire exec eyes Teale's business

By DOUGLAS McLEOD

ST. LOUIS—Bel-Aire Insurance Co. owner Arthur A. Blumeyer III is trying to take over blocks of insurance business written by insurers connected with Alan Teale, who has been jailed on multiple fraud charges.

The American Assn. of Parents & Children, an organization managed by Mr. Blumeyer's Evergreen Management Services Ltd., is soliciting risks that had been written by more than two dozen offshore companies, many of them linked to Mr. Teale and most of them banned from writing business in California and other states.

The AAPC is itself using two unrelated offshore companies to write at least some of this business: Atlas Insurance Co. Ltd. of the Turks & Caicos Islands and Olympian Insurance Co. Ltd. of Antigua.

The California Insurance Department recently notified several Olympian agents that it plans to disallow most of the insurer's reported \$23.9 million in assets and bar it from doing business in the state unless Olympian can verify the assets' worth and resolve other department concerns by March 3.

Mr. Blumeyer described recent AAPC advertisements for the

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Brokers' forecast brightens

By SALLY ROBERTS

The sun may be beginning to peek out behind the clouds that darkened the publicly held insurance brokers' results in 1992.

The soft property/casualty insurance market, the slumping economy and low interest rates continued to batter brokers' bottom lines in 1992. But signs of a market hardening, especially in property lines, and a healthier economy are giving the analysts who track them a glimmer of

Economy, market dampen '92 results

hope for 1993.

Brokerage executives, however, say they will not shift from their cost control-oriented strategies until they see concrete proof that better times are ahead.

While there have been some price hikes in property lines and in other areas like marine and

aviation, marketwide there has "not been too much activity. We're planning for a year much like '92," said Michael J. Clougherty, vp-finance at Arthur J. Gallagher in Rolling Meadows, Ill.

And overall 1992 results reflected "one more year of mediocrity," said Michael A. Smith, a senior vp and analyst with Lehman Bros. in New York.

However, 1993 "will be different," Mr. Smith predicts. He

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Update

Chicago hit by flood of lawsuits

Continued from previous page

lion of property damage and economic loss claims.

The litigation is significant because the insurers' policyholders all suffered property losses in the disaster, Mr. McCabe said. A judge last year dismissed economic damage claims filed against the city by businesses that did not sustain property damage (*BI*, Nov. 16, 1992).

The litigation charges the city, among other things, with willful and wanton misconduct in how it handled a bridge piling installation project in 1991. State law does not shield the city from liability for such charges.

The pilings, which were installed by Great Lakes, punctured an adjacent underground freight tunnel. Chicago River water flooded the tunnel and many connecting downtown buildings, closing many buildings for weeks (*BI*, April 27, 1992; April 20, 1992).

Mr. McCabe's suit also seeks to recover from Great Lakes' two surety bond underwriters, both units of Reliance Insurance Co.

ITT/Hartford Group Inc. filed the first subrogation suit connected with the flood in December (*BI*, Dec. 14, 1992).

\$107.3 million damage award

ROCHESTER, N.Y.—A jury last week ordered Teledyne Industries Inc. to pay \$107.3 million in compensatory damages to survivors of a family killed in a 1986 aviation accident, one of the largest awards ever in an aviation case.

The U.S. District Court jury here found that the Teledyne Continental Motor Aircraft Products division of the Mobile, Ala.-based manufacturer was strictly liable for an 1986 engine fire that killed Robert Gross, his wife, and two sons during an emergency landing in Winston-Salem, N.C.

Teledyne did not buy aviation product liability coverage in 1986, a London source said. During the mid-1980s, light aircraft manufacturers found it nearly impossible to buy product liability insurance.

Teledyne now buys aviation liability coverage through brokers Johnson & Higgins in Los Angeles and Willis Corroon P.L.C. in London. A London source said Teledyne now has \$400 million of aviation product liability insurance, which renews May 1.

Teledyne officials could not be reached.

Lawyers for the Gross family's survivors successfully argued Teledyne was made aware by Mr. Gross that the family's Beech Debonaire aircraft, which contained a Teledyne-made engine, was experiencing problems with fuel leaks.

The fire allegedly occurred when aviation fuel leaked onto hot exhaust pipes, forcing Mr. Gross to make an emergency landing. The entire craft caught fire upon landing, said Arthur Wolk of Wolk & Genter in Philadelphia, attorney for the Gross family survivors.

Teledyne will ask the trial judge to rule the award is excessive, according to Condon & Forsyth, its New York law firm. If the motions are denied, the verdict will be appealed.

World Trade Center explosion

NEW YORK—At least three people were killed and at least 300 others injured on Friday when the ceiling of a commuter train station under the World Trade Center in lower Manhattan collapsed.

The collapse, which was believed to have been triggered by an explosion one level above the underground station on the Port Authority Trans Hudson train line, caused the partial evacuation of the two 110-story World Trade Center buildings and knocked out the signals for most New York-area TV stations.

Authorities were investigating reports Friday afternoon that a terrorist bomb had caused the explosion.

Port Authority officials could not be reached for comment on the agency's insurance. One source said that the Port Authority is largely self-insured for property and casualty risks, although it probably buys excess insurance coverage in the commercial market.

A clerk at Hamond & Regine in Mineola, N.Y., acknowledged it was an insurance broker for the Port Authority, but did not have further information.

Court bars medical product suit

NEW ORLEANS—Another federal appeals court has ruled that manufacturers of some medical devices that are subject to regulatory approval are protected from personal injury lawsuits.

The Feb. 19 decision by the 5th U.S. Circuit Court of Appeals in New Orleans is consistent with an earlier ruling by a federal appellate court in Boston that specifically barred claims against so-called Class 3 medical devices scrutinized by the Food and Drug Administration (*BI*, Jan. 25).

In the latest ruling, the appellate court affirmed a lower court

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Errors & omissions

• Insurers opting for federal regulation under a proposal by Rep. John Dingell, D-Mich., would participate in a federal guaranty fund, a point not made clear in a Feb. 22 story.

1992 cat loss total soars with new Andrew figures

By MARK A. HOFMANN

RAHWAY, N.J.—A sharp increase in the official estimate of insured damages from Hurricane Andrew is driving total insured catastrophe losses for 1992 well beyond previous records.

Andrew's toll is now estimated at \$15.5 billion by the Property Claim Services division of the American Insurance Services Group.

The new estimate pushes total insured catastrophe losses for 1992 to \$22.97 billion, said Gary Kerney, director of catastrophe services for the Rahway, N.J.-based PCS.

Mr. Kerney noted that even without the new estimates of Andrew's damage, 1992 would have gone into the record books. In fact, the new 1992 total is more than three times as large as the previous record of \$7.64 billion set in 1989, when another hurri-

cane—Hugo—blew away previous records.

The new hurricane figures are the third estimate PCS has issued since Andrew tore across South Florida and slammed into Louisiana last summer (*BI*, Aug. 31, 1992). An initial estimate of \$7.8 billion was issued in September and revised to \$10.7 billion several weeks later (*BI*, Oct. 26, 1992).

In mid-December, A.M. Best Co. estimated that insured Andrew damage could reach \$16.5 billion (*BI*, Dec. 21, 1992). Best's estimate included costs such as loss adjustment expenses, which PCS does not tally in its calculations. PCS also does not include the minimum of \$500 million in marine and aviation losses caused by Andrew.

All of the PCS revisions have stemmed from changes in estimates of insured damage to South Florida. PCS's initial estimate of \$500 million in

Continued on page 4

Worker sues for fear of AIDS

Federal court to decide whether employer was negligent

By MICHAEL SCHACHNER

UNIONDALE, N.Y.—In a first-of-its-kind trial scheduled to begin today, a railroad worker is attempting to prove that his employer's negligence caused him physical injury as well as emotional distress from the fear of contracting AIDS.

In the first psychological injury case involving AIDS brought under the Federal Employers' Liability Act, a welder is suing the Long Island Rail Road,

claiming the company's failure to maintain safe working conditions caused him to prick his finger on a discarded hypodermic needle, raising fears that he could contract acquired immune deficiency syndrome.

To date, several state courts have issued differing rulings as to whether the fear of contracting AIDS is a compensable injury.

However, this is the first time that an AIDS phobia case resulting from employer negligence

will be heard in federal court. Because there is no precedent at the federal level, plaintiffs' and employer attorneys are watching the case of John Marchica, who was injured in 1989, when ordered to fix a grated window at a train station in Hempstead, N.Y.

Attorneys say that a verdict by the U.S. District Court in Uniondale, N.Y., in favor of Mr. Marchica could make it easier for employees to bring fear-of-AIDS

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Captive manager listing planned

Business Insurance will publish its annual directory of captive management companies in the April 26 issue, which also will contain a spotlight report on domestic and foreign captive domiciles.

There is no charge to be listed. To be included, companies must complete a questionnaire provided by *Business Insurance*.

The questionnaire also gathers information on policyholder-owned alternative risk financing facilities, which will be published in a chart in the July 19 issue.

The extended deadline for returning completed questionnaires is March 15.

If your company provides captive management services or manages an alternative risk financing facility, and you have not yet received a questionnaire, please request one from Kerry Dziubek at 312-649-5398.

New top Home exec will stay the course

By MARK A. HOFMANN

NEW YORK—An abrupt and unexpected change at the helm of The Home Insurance Co. last week does not signal a change in direction, says the insurer's new president and chief executive officer.

Lars-Goeran Nilsson assumed those positions last Monday, succeeding James J. Meenaghan, who retains his position as chairman of The Home's board.

The 44-year-old Mr. Nilsson currently is executive vp and head of the international division of Trygg-Hansa SPP Holding AB, the Stockholm, Sweden-based insurance holding company that is The Home's principal owner. The Swedish concern acquired the New York-based insurer from AmBase Corp. in early 1991 (*BI*, Feb. 18, 1991).

There will be "no change in The Home's direction" because of the management shift, said Mr. Nilsson, Home's fourth CEO in the past decade. He said the insurer will continue to focus on large commercial specialty risks.

In addition, "we intend to make use of the international structure" of Trygg-Hansa and The Home to expand the U.S. insurer's international capabilities, he said.

An analyst who has followed the fortunes of The Home Insurance Co. it-

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Mr. Nilsson



Mr. Meenaghan

Inside

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✓ Employers worry about workers comp medical costs, but relatively few use managed care to contain them, a Johnson & Higgins survey says. **PAGE 16**

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Investors sell HMO stocks at feverish pace

Proposed Medicare payment freeze, California HMO rate cut rock market

By JOANNE WOJCIK

Health maintenance organization stock prices finally began to level off last week after a two-week free-fall triggered by the California Public Employees Retirement System's Feb. 10 announcement that it had strong-armed its HMOs into accepting a rate cut.

TAKING STOCK



The situation was exacerbated by President Clinton's announcement on Feb. 14, repeated during his Feb. 17 State of the Union address, that he would seek a freeze on payments to doctors and hospitals that treat Medicare beneficiaries.

And continued speculation over the health care reforms Hillary Rodham Clinton's task force is to unveil this spring has further fueled a bailout by HMO investors, analysts say.

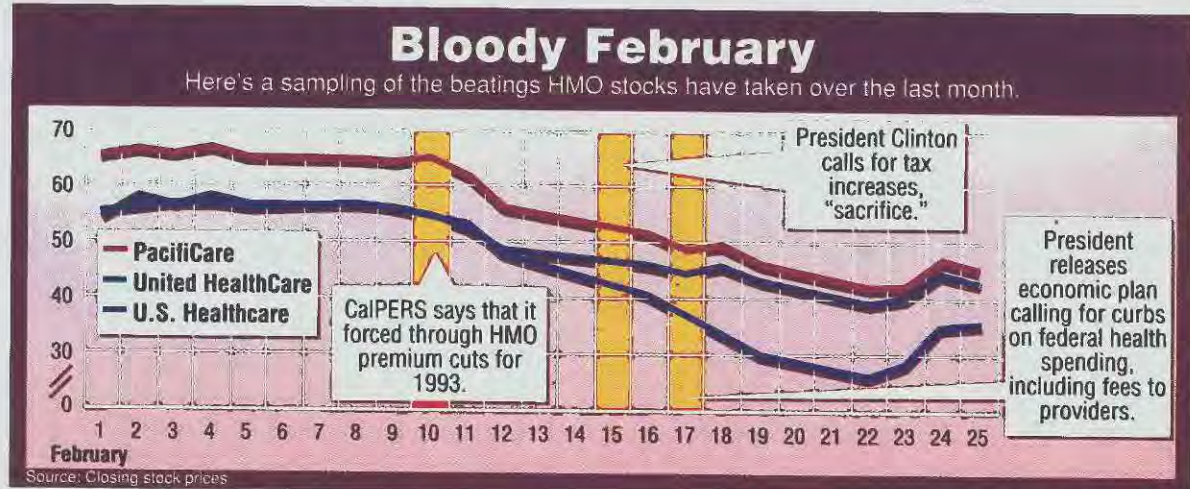
The aggregate price of seven publicly traded HMOs tracked weekly by *Business Insurance* fell 11.5% from Feb. 8 through Feb. 12, and dropped 14.2% from Feb. 16 to Feb. 19. By last week, though, HMO stocks had recovered somewhat (see *BI* Stock Index, page 31).

Among the hardest hit were Cypress, Calif.-based PacifiCare Health Systems; Minneapolis-based United HealthCare Corp.; and Uniondale, N.Y.-based U.S. Healthcare Inc. (see chart).

But many industry observers insist that investors' knee-jerk reaction is naive, since any reforms that expand access to health care are certain to increase HMO profitability in the long run.

And others say the event believed to have started the selling spree—CalPERS' announcement—was misleading since the state agency failed to point out that much of its HMO cost savings was due to alterations in its benefit plan that shift costs to employees (*BI*, Feb. 15).

Still, many HMO stocks are not expected to recover any time soon as investors grow more selective.



GRAPHIC BY A. TRANCHITA

HMO stocks began climbing shortly after the Democrats took control of the White House, peaking in early February.

Much of the initial speculation was fueled by the belief that the already-thriving HMO industry would be a big winner if the health care delivery system is overhauled as promised by the president.

Without releasing details of his package, Mr. Clinton already has embraced a managed competition model in which purchasing cooperatives would negotiate rates and coverage with provider networks comparable to HMOs.

As a result, "HMOs stand to grow significantly under any re-

forms short of a total government-run system," said Kurt Davis, director of investor relations for Foundation Health Corp., a Rancho Cordova, Calif.-based HMO.

But CalPERS' announcement earlier this month that it will hold indemnity plan increases to 1.5% and actually reduce HMO premiums 0.2% made investors think twice about the safety of their HMO holdings, analysts concur.

"Many investors saw it as a precursor to health care reform and as a squeeze on (profit) margins," observed Ellie Kerns, an HMO stock analyst with Alex. Brown & Sons Inc. in Boston.

"But this was a local issue that made the national press," said Ms. Kerns, pointing out that what happened in California may not be duplicated elsewhere due to the state's high HMO enrollment and poor economic condition. California's recession has forced many HMOs to acquiesce to price reductions to keep market share as more and more employers leave the state or lay off workers, she explained.

CalPERS' announcement also failed to mention that much of its rate cut was the result of hiking employee copayments, pointed out Foundation's Mr. Davis.

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RETIREE BENEFITS

Firm allowed to cancel cover

Company documented the right to terminate plan: Court

By JOANNE WOJCIK

CINCINNATI—Employers that reserve the right in plan documents to terminate retiree health care benefits cannot be forced to continue those benefits, a federal appellate court has ruled.

The Feb. 18 ruling by the 6th U.S. Circuit Court of Appeals in Cincinnati sets aside a permanent injunction that had prevented Universal Components Corp. from cutting off health care benefits to a group of 30 retirees of a company it purchased in 1984.

A U.S. District Court judge in Grand Rapids, Mich., had found that the retirees' health benefits were protected under the Employee Retirement Income Security Act of 1974 and ordered Universal Components to continue to pay premiums for the rest of the retirees' lives.

However, the 6th Circuit Court ruled that governing plan documents clearly retained the right to terminate retirees' coverage on 30 days' notice.

Furthermore, the appellate court said that although pension plans are subject to mandatory participation, vesting and funding requirements under ERISA, welfare benefit plans like health insurance programs are not.

"This decision endorses the principle that the plan documents govern participants' rights under the plan rather than leaving participants' rights and benefits to the vagaries of oral assurances or representations," said Fred A. Ricks Jr., the attorney who represented Universal Components in the case.

Although the 30 retirees who sued Universal in federal court maintained they were promised

Continued on page 4

'Hands-off' approach

Liquidated firm's retirees design, administer own plan

By SALLY ROBERTS

SOUTH BEND, Ind.—Letting retirees design and administer their own employer-funded health care plans may seem a little crazy, but that's what liquidated Uniroyal Plastics Inc. is doing.

About 2,500 Uniroyal retirees recently struck such a deal with Jesup Group Inc., the company that bought then-ailing Uniroyal in 1986 and later filed for bankruptcy protection itself.

Jesup, which emerged from bankruptcy late last year, is paying \$2.5 million annually to a non-profit corporation made up of Uniroyal retirees. Since Jan. 1, the corporation, Uniroyal Retiree Benefits Inc., has been administering its own health plan and determining its design and benefits levels.

Negotiations with retirees began in 1991 when

Jesup, after filing for bankruptcy protection under Chapter 11 of the Federal Bankruptcy Act, stopped paying claims from its self-insured medical plan.

Once Jesup agreed to pay, retirees were able to tailor a health plan to their needs, said Randy Light, senior manager for Crowe, Chizek & Co., the South Bend, Ind., consulting firm that helped design the plan.

First of all, they wanted "to be totally separate from Jesup," he said.

Second, they wanted a fully insured plan so if Jesup became financially strapped again, their medical bills would be paid, he said. Now retirees are covered by a group policy from United Wisconsin Life Insurance Co. of Milwaukee.

Retirees are required to pay copayments of \$15 per office visit, \$150 per-night of hospitalization and \$25 for X-rays.

The benefit plan reimburses medical providers at Medicare rates. Some hospitals and doctors will not agree to those fees, Mr. Light con-

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Congress may turn attention to redlining

By MARK A. HOFMANN

WASHINGTON—Insurers could face new reporting requirements if Congress acts on allegations of insurance industry redlining.

In fact, redlining charges could potentially overshadow issues like federal regulation of insurer solvency and reform of the McCarran-Ferguson Act, says an industry lobbyist who testified last week before a congressional subcommittee.

Redlining—the illegal practice of systematically discriminating against minority or inner-city areas—came under the scrutiny of the House Banking Committee's Subcommittee on Consumer

Credit & Insurance last week. Another House subcommittee has scheduled a hearing on redlining for this week and the Senate may examine the matter later this year.

"It looks like this may end up being the leading issue in the casualty area," said David M. Farmer, vp-federal affairs for the Alliance of American Insurers in Washington, after testifying.

"No individual is denied property insurance based on race, ethnicity, or simply because of the geographic location of their property," said Mr. Farmer, who added that if an insurer does redline, it should be prosecuted.

Continued on page 26

Managed competition defended for rural areas

By DAVE LENCKUS

JACKSON HOLE, Wyo.—The managed competition concept could help even rural Americans obtain affordable quality health care—with more management by the government and rural health care purchasers, according to the Jackson Hole Group.

In a draft paper, the Jackson Hole Group outlines how a rural authority created by the federal government could attract providers from nearby urban areas to service rural areas by, among other things, offering subsidies or exclusive franchise agreements for the area.

An organization representing health care purchasers would monitor the price and quality of health care services in its area.

However, a co-author of a recent study suggesting that managed competition may not be suitable for small urban and rural areas still questioned whether the concept would work in rural areas.

As envisioned by the Jackson Hole Group, managed competition—which President Clinton supports—would ensure universal coverage by requiring all employers to sponsor health plans and all individuals to buy coverage.

Under the concept, the federal government would establish a core package of benefits. Large and small employer groups and individuals would band together to form health plan purchasing cooperatives. Groups of providers and health insurers, known as accountable health plans or AHPs, then would compete for these HPPCs' business based on price and quality.

Continued on page 17

Retiree benefits

Continued from page 3

that benefits would continue for the rest of their lives, top corporate officials testified that they had made no such representations.

In fact, a plan booklet circulated to employees in 1976 stated: "Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued."

In addition, a similar reservation of rights was included in a Blue Cross & Blue Shield of Michigan conversion plan that Universal arranged for the retirees in 1984, after it purchased their former employer, Douglas Components, from Scott Fetzer Co. and terminated a health care plan written by Aetna Life & Casualty Co., according to court

papers.

In October 1989, Universal sold a major part of its operation to Douglas Autotech Corp. and four months later notified BC/BS of Michigan that it intended to drop coverage for non-union retirees.

An April 30, 1990, letter to the retirees advised them their health insurance would terminate on June 1, 1990, court papers show.

However, after receiving the cancellation notices, a group of retirees filed suit under ERISA seeking injunctive relief and damages.

Although the retirees won their argument at the trial court level, the appellate court found the district court's decision was erroneous.

The retirees argued that "Universal Components' duty to provide health insurance arises

from verbal assurances by the defendant that the plaintiffs would receive health benefits for life."

But the appellate court said the BC/BS of Michigan documents "are the controlling plan

who is with McMahon, Berger, Hanna, Linihan, Cody & McCarthy in St. Louis.

"The trend has been to look to the governing plan documents," he said.

Indeed, the appellate court

The 6th Circuit Court's position that plan documents govern the status of retiree benefits is inconsistent with how the 9th U.S. Circuit Court of Appeals has ruled, says Harry Rossbacher, the attorney representing McDonnell Douglas retirees.

documents and that any verbal assurances by Universal Components do not constitute a plan."

The ruling is consistent with several earlier decisions involving retiree health benefit terminations, according to Mr. Ricks,

cited several earlier decisions supporting its position dating back to 1988, when the 6th Circuit Court also ruled in *Musto vs. American General Corp.* that "the written terms of the plan documents control and cannot be

modified or superseded by the employer's oral undertakings."

In finding that ERISA does not provide for vesting of retiree health benefits, the appellate court additionally cited its groundbreaking 1986 *White Farm Equipment Co.* decision (*BI*, May 12, 1986).

It is uncertain whether the Universal decision will be cited by McDonnell Douglas Corp. to defend a suit brought by a group of Southern California retirees seeking to have their health benefits reinstated (*BI*, Dec. 7, 1992).

To reduce its retiree benefit liabilities under Financial Accounting Standard 106, the St. Louis-based aircraft manufacturer on Jan. 1 replaced its non-union retiree medical benefit plans with a four-year retiree-pay-all health plan. That plan is funded by surplus defined benefit pension plan assets (*BI*, Oct. 19, 1992).

McDonnell Douglas declined to comment on the Universal Components' retiree case because of its involvement in similar litigation.

However, Harry Rossbacher, the attorney representing McDonnell Douglas retirees, said the 6th Circuit Court's position that plan documents govern the status of retiree benefits is inconsistent with how the 9th U.S. Circuit Court of Appeals has ruled. The 9th Circuit Court includes Los Angeles, where the McDonnell Douglas retirees filed suit.

"This is a really odd, bizarre decision," said Mr. Rossbacher, who is with Rossbacher & Associates in Los Angeles. "It just doesn't follow."

The McDonnell Douglas suit relies on the 9th Circuit Court's 1984 decision in *Bowers vs. Bunker Hill Co.*, which says "that you have to look at everything before deciding whether lifetime benefits were promised," he noted.

For example, while plan documents may state that a particular policy may be terminated at some time in the future, "that means a particular policy, not the benefits entirely," Mr. Rossbacher stressed, adding there are several insurance contracts involved in the McDonnell Douglas case.

Boyer vs. Douglas Components Corp., 6th U.S. Circuit Court of Appeals, CA 6, No. 91-2098, Feb. 18, 1993.

Cat losses

Continued from page 2

insured damage to Louisiana has remained constant since September.

Mr. Kerney said insurers will ultimately receive about 625,000 claims from Florida policyholders. As of late February, almost 600,000 claims had been filed and 90% of those had been settled. Damages to houses and their contents accounted for about two-thirds of the claims, he said. Another one-fourth stemmed from damage to automobiles and about 10% were due to business losses.

Mr. Kerney added that several other factors could ultimately push claims costs higher. These include: an increase in rebuilding costs; additional rain damage; and additional living expense coverage. None of these factors by itself represent "a significant cost increase," although in combination they could affect the estimate. **BI**

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Assistant Vice President
Finance & Administration
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ROGER ABLETT
Vice President
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ART PHILLIPS
Executive Vice President
Specialty Lines Division
(212) 530-7201

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TIM WILLIAMS
Assistant Vice President
General Aviation
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FRED FONTEIN
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Assistant Vice President
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DON BROMBERK
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(404) 240-5312

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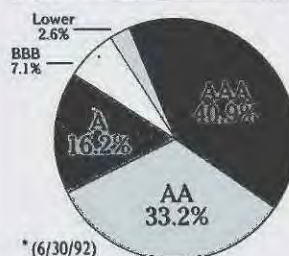
AIG Ratings:	
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*Domestic Property-Casualty Companies	

measure of a company's financial strength. AIG holds the highest ratings awarded by the principal agencies. They are a prized asset, enabling us to capitalize on business opportunities not open to those without these credentials.

Are there substantial differences in the way insurance organizations are managed?

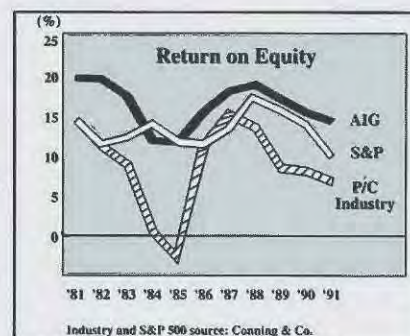
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Letters

Continued from page 8

With 25% of these workers already involved with care-giving responsibilities, employers are forced to contend with issues of increased absenteeism, physical and financial stress, and work interruption.

To remain competitive through the 1990s and into the 21st century, American business will need to make changes in policy to accommodate the needs of their workforce. With few exceptions, business has been slow to respond to these demographic trends.

The age group 85 and over is the fastest-growing segment of our population. Those charged with their care have an essential need to access information and services with confidence and ease.

President Clinton should go beyond signing the family leave law and promote activities within the workplace that directly aid employees in obtaining the tools they need to remain productive while caring for parents and children. Among these would be to encourage dependent care benefits, seminars, resource fairs, and information and referral to community care-giving services.

President Clinton also should expand his proposed national service program to include all ages and income groups and to make use of the talents and skills of early retirees, most of whom can look forward to almost 40 years of retirement. Such a broad-based national service would promote intergenerational understanding.

Dolli Cutler
Executive Director
Senior Alliance Inc.
Oxnard, Calif.

Insurers need to reconsider reserves now

To the editor: The Feb. 1 issue of *Business Insurance* contained a page 1 article as well as an editorial dealing with reserve levels for the property/casualty industry; unfortunately, neither one goes far enough.

According to the article, some analysts and insurer executives say insurers will choose to increase reserves in 1992 because of already poor results, rather than wait until a more profitable year. Other insurers will not have the financial flexibility to add to loss reserves on top of 1992 catastrophe losses, they say. An example, one observer says, "would be someone on the edge" financially that cannot afford to add to reserves.

No one seems to get it. Doesn't the insurance industry know that a common charge in directors and officers liability lawsuits relates to the filing of false and misleading financial statements? We are talking about the law here, not a discretionary or face-saving option.

If the industry were to act responsibly en masse, who knows—it might just have the salutary effect of providing a market turn.

Herbert H. Feldman
President and
Chief Executive Officer
Alpha Risk Management Inc.
Great Neck, N.Y.

Home changes

Continued from page 2

several years agreed with Mr. Nilsson's assessment.

"Management is important, but then again, any one person usually only has a limited impact on a company. We're not expecting any strategic changes in the company. We know the owner was comfortable with the strategy Jim Meenaghan was implementing, so we're not anticipating any changes," said Alan M. Levin, senior vp-insurance rating services for Standard & Poor's Rating Group located in

New York.

Although The Home declined to give a specific reason for the management change, Mr. Nilsson insisted there was nothing unusual about the move. "This is being done in an ordinary and positive manner."

In a statement, Bjoern Sprængare, chairman of Trygg-Hansa SPP Holding, praised Mr. Meenaghan's years as The Home's chief executive.

"Over the past seven years, Jim Meenaghan has done an extraordinary job leading The Home through a very difficult period under the previous owner and in

the last two years has very effectively helped The Home regain a leadership role in the industry," Mr. Sprængare said.

"Jim is going to continue as chairman and give us counsel from that function," Mr. Nilsson added.

In addition, The Home has begun searching for a chief operating officer, which is a newly created position that will report to Mr. Nilsson. "We are going outside Home" to identify candidates, he said.

Mr. Nilsson joined Trygg-Hansa in 1972. Since the Swedish concern acquired The Home

in 1991, he has served as executive vice chairman of Home Holdings Inc., the holding company for the insurer, as well as chairman of the insurer's executive committee.

Mr. Meenaghan, 54, joined The Home in 1986. He was previously president and chief executive officer of John F. Sullivan Co., a Seattle-based reinsurance brokerage.

Prior to that, Mr. Meenaghan was president and chief operating officer of Fireman's Fund Insurance Co.

Mr. Meenaghan was unavailable for comment. **BI**

THE HOME



OLD PROS ON

Blumeyer

Continued from page 1
business as a "fact-finding" exercise.

"We are trying to find out what's out there," he said. "What we thought was going to happen after Alan (Teale) blew up—a binge of prospective business out there—hasn't turned out to be much."

Mr. Teale and his wife, Charlotte C. Rentz, were arrested in January on federal charges that they operated a vast network of U.S. and offshore companies that defrauded thousands of policyholders out of millions of dollars (BI, Jan. 25).

Mr. Blumeyer said his plan was to have Atlas and Olympian "re-underwrite" business written by Mr. Teale's companies and others, raising rates and presumably making the business profitable.

If enough business materialized, Mr. Blumeyer said, he would also consider forming risk retention groups or offshore captives to underwrite it.

"I was hoping we would come up with a big block of errors and omissions, daycare (and) water park" business, as well as a book of accident and health risks, he said.

So far, though, the AAPC has only had about half a dozen inquiries,

Mr. Blumeyer said.

The use of unlicensed offshore insurers has created problems for the AAPC and Evergreen in the past.

The Washington Insurance Department last year hit the AAPC with a cease and desist order after finding it produced business for the now-defunct Marigot Casualty Co. Ltd. of Anguilla.

Marigot's London-based lawyers notified the National Assn. of Insurance Commissioners last November that Marigot was disclaiming liability on any business written in the United States, saying that the insurer never authorized any U.S. underwriting. Mr. Blumeyer disputes

this contention.

Mr. Blumeyer later said the AAPC would use Tiberian Insurance Co. Ltd. of Anguilla for a variety of property/casualty risks. However, California regulators barred Tiberian last year (BI, May 4, 1992).

Meanwhile, St. Louis-based Bel-Aire, which Mr. Blumeyer formerly headed, has been under Missouri Insurance Department control since 1990. A state judge last year declined to order Bel-Aire liquidated but continued Insurance Department supervision (BI, Nov. 30, 1992).

AAPC is a Delaware-based non-profit corporation formed to "pro-

vide support for the American family and reverse the decline of the American educational system," says the group's promotional literature.

AAPC brochures describe the group's goals as helping parents participate in and finance their children's education and lobbying for "positive educational change on the local and national level."

Benefits offered to AAPC members for a \$25 annual fee include newsletters and educational materials; scholarships for needy students; discounts on "everything from air travel to zoo tickets;" and "low cost business liability insurance," the brochures say.

The AAPC has offered members a variety of property/casualty insurance products, particularly in California.

These have included commercial and private passenger auto coverages, as well as programs for skating rinks, special event sponsors, tanning salons, daycare centers, construction contractors, amusement and water parks, trucking companies and insurance and real estate agents.

Asked what connection this business has to AAPC's family- and education-related goals, AAPC founder H. Allen Lowther explained it as part of a drive to expand the association's membership.

Mr. Lowther, based in AAPC's office in Naples, Fla., said he turned over management of the AAPC to Mr. Blumeyer and Evergreen more than a year ago. Since Evergreen was already involved in placing commercial coverages, AAPC sought to build membership by having Evergreen clients join the association to obtain coverage under an AAPC master insurance policy, he said.

AAPC now has roughly 10,000 members, mainly in California, Florida and Ohio, Mr. Lowther said. About 60% are families and 40% are insurance buyers brought in by Evergreen, he said.

Conceding that families would have little use for the types of coverage Evergreen markets, Mr. Lowther said AAPC is developing new markets to provide life and health, auto and homeowners insurance to family members.

The AAPC does not receive any fees from the insurance sales and derives most of its revenues from membership fees and member discount programs, said Mr. Blumeyer, an AAPC board member.

To date, the AAPC has granted about 14 scholarships to disadvantaged students, none for more than \$2,000, according to Mr. Lowther. The group also helps parents identify other public and private sources of scholarship money, he said.

The AAPC last month started advertising for commercial insurance business that had been written by 26 offshore insurers, many of which were allegedly controlled by Mr. Teale and many of which have been shut down or barred by U.S. regulators.

"Were you working with any of these companies?" the ads asked before listing the insurers by name. "We can help. Call us and find out how we can help you place any and all of your business."

Ironically, one of the companies named in the ad is Tiberian, which Mr. Blumeyer last year said he was using to write AAPC business.

Asked last week why he mentioned Tiberian in the ad when he was using the company himself, Mr. Blumeyer replied, "Why not? So were a bunch of other people."

He confirmed that AAPC is now using two other offshore insurers, Atlas and Olympian, to write property/casualty business for AAPC members in California.

Continued on next page

E T O D A Y

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And obviously, risks like these don't stop at the water's edge.

Home Insurance

A N E W T E A M

Blumeyer

Continued from previous page

Atlas, licensed in the Turks & Caicos, reported total assets of \$9.3 million as of May 31, 1992, according to a financial statement audited by Jack McNulty, a Los Angeles certified public accountant.

Equity securities valued at \$9.2 million make up most of the total, and include \$1.65 million in stock of a related Nevada-based company, SKS Investments Inc., according to the statement, which provides no further details of other holdings.

Atlas also reports \$102,200 in cash held by its parent, Atlas America Investments Inc.

Finding an Atlas official willing to talk about the company's operations proved difficult.

Nevada corporation records show that Atlas America is headed by Sukhbir K. Singh, who is also an officer of SKS and Lotus Management Group Inc., an Atlas management firm.

She also is a California-licensed fire and casualty agent and broker doing business as Hermann Insurance Brokerage from an office on Wilshire Boulevard in Los Angeles, California records show.

Atlas' sponsoring surplus lines broker is Monika Insurance Services, headed by George Singh and

located at the same Wilshire Boulevard address.

In an interview, George Singh said he is not a director or officer of Atlas and referred questions to a lawyer in the Bahamas, who could not be reached.

George Singh at first also denied knowing Sukhbir Singh. When it was pointed out that California records showed her operating Hermann Insurance Brokerage at the same address, he said, "She used to be here four or five years ago, but not anymore."

Sukhbir Singh could not be reached. A receptionist at Hermann said she was "in and out" during the day and referred questions about Atlas to George Singh.

Ashok Shah, also listed in Nevada corporation records as an officer of Atlas America and Lotus Management, said he only handles tax accounting for Atlas. He referred questions to Atlas' Turks & Caicos-based manager, who could not be reached.

Atlas wrote \$357,472 in premiums in California last year, according to state Surplus Lines Assn. figures reported to the California Insurance Department.

Olympian, based in Antigua, reported \$23.9 million in assets in a June 30, 1992, financial statement audited by Chris Norbert & Co. in

London.

The total includes \$17.1 million in equity securities. The statement notes that securities originally contributed to Olympian were exchanged for other investments of equal value, though none of the securities is identified.

In an interview, Eugene C. LaVelle Jr., a vp with Bryen International Inc. in St. Petersburg, Fla., which is Olympian's management company, said that the original securities were of Bestway Elevator Corp., a New York company controlled by Olympian's owner, Nathan Glick.

The Bestway shares have been exchanged for equity in The Braustein Group, which Mr. LaVelle described as a London-based real estate firm.

"Why they did that, I don't know," Mr. LaVelle said.

Olympian's other assets include \$4.6 million in premiums receivable, though a note to the statement reports that Olympian was suing one of its surplus lines brokers for allegedly failing to remit a large amount of those funds.

Mr. LaVelle identified the broker as KD Excess & Surplus Insurance Services of Irvine, Calif., and said the litigation has been settled.

Under the settlement, Olympian

ceded 100% of its risk on the KD business to another offshore insurer and received \$225,000 that was being held in a California trust account, according to KD's owner, Michael Kwiatkowski.

Mr. LaVelle said that Olympian is preparing a year-end 1992 statement. With the removal of the KD premium receivable and the infusion of Braustein assets, "everything on there has changed," he said.

"The financial statement for year-end 1992 will be considerably stronger than the June 30," Mr. LaVelle said.

Nevertheless, the California department has notified Mr. Kwiatkowski and other Olympian brokers in the state that it intends to disallow most of the insurer's assets and bar it from doing business in the state unless Olympian can convince it otherwise.

Among other things, the California Insurance Department letter says Olympian was unable to prove ownership of its Braustein Group assets and that it is "highly questionable" whether they would meet the liquidity standards of state law in any case.

The California department also said that it intends to disallow the KD premium receivable and several other Olympian assets, and that as a result Olympian would show nega-

tive surplus of \$5.4 million based on its June 30, 1992, statement.

Noting that Olympian's management had promised and failed to produce requested documents, the department letter also criticized "a course of conduct on the part of Olympian's management which is characterized by misrepresentation (inadvertent or not) of material facts concerning the financial status of the company."

Unless Olympian provides "substantial convincing counter-arguments" by March 3, the department said it would order brokers to stop placing business with the insurer on March 10.

Olympian wrote \$5.8 million in premiums in California last year, including \$470,660 of purchasing group business, according to Surplus Lines Assn. figures.

Mr. LaVelle and Olympian President Catherine Gay could not be reached for comment on the department's letter.

Mr. Blumeyer also could not be reached, though in an earlier interview he expressed guarded confidence in both Olympian and Atlas.

"What I've seen looks pretty good," he said.

"But then again," he added later, "what's a solid company today? What's solid anymore?" **BI**

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Caleb Fowler resigns from CIGNA P/C unit

Comings & goings: Industry

After 27 years with the company, **Caleb Fowler** has resigned as president of CIGNA Corp.'s domestic property and casualty unit in Philadelphia.

Mr. Fowler, 50, is leaving to pursue other opportunities. A successor will be named in mid-March; until then, Chairman and Chief Executive Officer Wilson Taylor will handle the president's responsibilities.

In other insurer changes:

John A. Rowney elected chairman of the Water Quality Insurance Syndicate in New York, a pollution liability insurance pool for vessel operators. Currently, Mr. Rowney is president of the ocean marine division of Great American Insurance Co. of Cincinnati.

Lake Forest, Ill.-based Benefit Trust Life Insurance Co. recently announced several promotions: **John Ames** was named vp and actuary-group; **Dr. Howard Lubar** was named chief operating officer-benefit health care solutions; **Barbara J. Wurfel** was named vp of administration-group; and **Dan Winslow** was named vp and actuary for subsidiary Star Marketing & Administration Inc.

Richard G. Lambert has been named president of agency management/sales for the United States Fidelity & Guaranty Co. in Baltimore.

Douglas H. May recently joined The Home Insurance Co. in New York as vp. Previously, Mr. May was vp-field offices at American International Group Inc.

Mutual of America Life Insurance Co. announced several appointments: **William S. Conway** to executive vp-marketing; **Rita Conyers** to executive vp-communications; and **Thomas E. Gilliam** to executive vp-technical operations.

Agents/brokers

John C. Adams Jr. named executive vp and chief operating officer of Hilb, Rogal & Hamilton Co. in Richmond, Va.

Allan M. Scott recently joined

Schiff, Kreidler-Shell Inc. in Cincinnati as vp in charge of surety operations.

Shirley D. Griffith recently joined the entertainment division at Rollins Hudig Hall Co. in Chicago as executive vp.

Reinsurance

Albert J. Beer recently joined American Re-Insurance Co. as senior vp in Princeton, N.J.

Bermuda-based Centre Reinsurance Holdings Ltd. recently announced several new promotions: **Thomas R. Dickson**, **Steven D. Germain**, **Frank D. Pierson**, **Jay S. Ralph**, and **Eileen M. Sweeney** have been named senior vps. Also, **David Brown** recently joined Centre Reinsurance Bermuda Ltd. as senior vp, and **Tom Fink**, **Judy King** and **Scott Roberts** joined the company as vps.

In addition: Centre Reinsurance Cos. of New York recently announced the addition of **Richard E. Smith** as senior vp, and **Mary Ann Eddy** as vp, responsible for underwriting finite risk insurance and integrated reinsurance transactions. **Michael Hamer** has been appointed chairman of Centre Reinsurance Representatives in London; and **Philip Harkin** recently joined Centre Reinsurance International in Dublin as vp-underwriting.

Other suppliers

Timothy E. Murnane was named president and chief operating officer of MEDSTAT Systems Inc., a health care information company in Ann Arbor, Mich. Also at MEDSTAT: **Michael J. McGowan** named vp and general manager of the employer business unit; **William J. Rauwerdink** joined The MEDSTAT Group, a new holding company, as executive vp and chief financial officer; and **Jennifer S. Ponski** named vp-corporate development for MEDSTAT Group. **BI**

• 1992 •
GROUP HEALTH CARE COSTS

Indemnity plans

Continued from page 1
 gins' New York office.

The Foster Higgins survey, to be released this week, is based on the responses of 2,448 employers. It is the largest survey of its kind.

Aside from the cooling of health care inflation from ultra-high levels, the most striking finding in the survey is the large and increasing cost differential between traditional medical indemnity plans and managed care programs.

Traditional indemnity plan costs topped \$4,000 per employee for the first time in 1992, rising 14.2% to \$4,080 on average from \$3,573 in 1991. While overall group health care costs rose more slowly than in 1991, the 14.2% increase in indemnity plan costs in 1992 exceeded the 1991 increase of 13%.

The cost of traditional indemnity plans is likely to continue to soar as some employer's plans are trapped in a spiral, in which only the sickest employees remain in indemnity plans, while more healthy employees opt for managed care programs. That means higher demand for services and bigger cost increases for employers with traditional indemnity plans, Mr. Erb said.

The cost increases for all types of managed care programs were lower—strikingly so—than the rise in traditional indemnity plan costs.

Costs for point-of-service plans, in which employees are enrolled in an HMO-type network but can receive coverage for out-of-network services, climbed 8.4% to \$3,566 per employee on average, from \$3,291 in 1991, while HMO costs increased a shade more—up 8.8% to \$3,313 from \$3,046.

The cost of indemnity plans with a preferred provider organization component rose 10.5% to \$3,708 from \$3,355.

The average cost of a traditional indemnity plan was 23.2% higher in 1992 than the average HMO cost, 14.4% higher than the average point-of-service plan cost and 10.1% higher than the average PPO cost.

That finding proves that managed care plans can and do dampen health care inflation, Mr. Erb said.

The success of managed care plans—relative to traditional indemnity plans—is not going unnoticed by employers and employees.

More employers, for example, are dropping traditional indemnity plans for some type of managed care arrangement. This is causing a surge in managed care plan enrollment.

Last year, for the first time in the survey's history, a majority—52%—of eligible employees were covered by managed care plans, up from 45% in 1991.

Still, Clinton administration officials, who are drafting legislation to revamp the nation's health care system to expand enrollment in managed care programs, should look at managed care enrollment statistics carefully, Mr. Erb cautioned.

During the campaign, President Clinton emphasized the concept of "managed competition" in which giant HMO-like entities would be organized and contract with providers (see story, page 3).

But administration officials should be aware that HMOs are not the only plan design option in a managed competition setting, Mr. Erb said.

"If employees had to enroll in HMOs, it would be a wrenching change for the vast majority of the insured population," Mr. Erb said, noting that only 26% of eligible employees are enrolled in HMOs.

At the same time, while enrollment in managed care plans has

increased, there are big regional variations. For example, in the Pacific states, 82% of employees participate in managed care plans, compared with just 35% in the Mid-Atlantic states.

Similarly, increases in total health care costs also varied considerably by region. For example, health care costs leaped an average of 17% among employers in the South Central states, rising to \$3,809 from \$3,256.

Ironically, the expansion of managed care plans may have contributed to the big jump. Many employers in the South Central states recently added PPO options to their indemnity plans but may have offered benefits that were too rich, Mr. Erb said.

In addition, many of the new PPO
Continued on next page

Employers uncertain about UR gains

Employers aren't sure whether their utilization review programs are saving any money.

But that doesn't mean UR programs are not effective, a benefit consultant says.

Seventy-one percent of employers with indemnity plans said they didn't know the impact of their UR programs on medical costs, according to the Foster Higgins survey.

Employers may be unable to measure the impact of their UR programs because the programs often were added years ago and the changes in provider behavior occurred some time ago, notes John Erb, a principal with Foster Higgins.

"The ultimate objective of UR programs was to change physician behavior and that has occurred. Physicians have become, for example, more careful about keeping employees in hospitals longer than necessary," he said. Abandoning UR programs

would be a mistake for employers because doctors would return to their old ways, Mr. Erb said.

Twenty-one percent of employers said their UR programs lowered their medical plan costs and 7% said UR had no effect. Among the employers that said UR lowered medical costs, the average savings was equal to 6% of total plan costs.

The most common component of a UR program—used by 83% of the respondents—is precertification of elective hospital admissions; 69% offer case management of catastrophic claims, like a premature baby; and 66% offer concurrent review of services.

In addition, 45% of UR programs require mandatory second opinions for selected surgical procedures; and 26% of UR programs offer voluntary second opinions, for which the plan will pay the full cost.

—By Jerry Geisel

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Insurers haven't junked high-yield issues

Some new junk bonds issued; many others not yet retired

By JUDY GREENWALD

Junk bonds, considered a legacy of the feverish merger and acquisition activity of the 1980s, still are an element of financing in the property/casualty insurance industry.

While many of these high-yield issues that are outstanding date back a decade or more, some junk bonds have been issued recently.

Most notable of these in the property/casualty area is the junk bond issue by American Re-Insurance Co.'s holding company, American Re Corp., in connection with its recent leveraged buyout (BI, Aug. 24, 1992).

In fact, analysts say, most junk bonds issued by insurance companies in the future are likely to be in connection with LBOs, rather than part of efforts to raise capital.

Junk bonds are bonds issued with a credit rating of BB or lower from rating agencies. They pay higher yields than investment-grade issues because of their greater perceived risk of default. They often are purchased by mutual funds for their higher yields. Factors that cause a company's bond rating to be below investment grade include a high percentage of debt relative to capital.

There currently is about \$3.5 billion in outstanding junk bonds issued by the insurance industry, said David Wells, who analyzes these issues for Bear,

Stearns & Co. in New York.

That amount is only half of the \$7 billion in outstanding junk bonds issued by oil and gas companies, but is more than the \$2 billion in bonds outstanding for both the food and beverage and publications industries, he noted.

The junk bond issue in connection with American Re's LBO comprised \$450 million in bonds with a 10½% interest rate, said Monte Blanchard, managing director at Merrill Lynch & Co. Inc. in New York, which served as American Re's investment banker.

Proceeds of the offering were used by LBO specialist Kohlberg, Kravis & Roberts as part of a \$1.4 billion package to acquire the reinsurer from Aetna Life & Casualty Co.

American Re completed an initial public offering earlier this year noted James Fisher, American Re's senior vp and chief financial officer. American Re in January offered 11.6 million shares at \$31 per share, for a total of about \$359.6 million (BI, Feb. 1). Part of the proceeds of the offering was used to pay down bank debt.

Last week, Standard & Poor's Corp. increased American Re's subordinated debt rating to BB+ from B+.

In addition, American Re's claims paying ability rating was increased to AA- from A-.

Thereafter, both ratings were removed from S&P's Credit-

Watch.

Meanwhile, many outstanding junk bonds in the insurance industry date back at least several years.

Among them is Reliance Group Holdings Inc., which last had a junk bond issue in 1988 and now has \$675 million in non-investment grade debentures and notes outstanding, according to a spokesman for the Philadelphia-based insurance and financial services company.

That includes \$180 million in "split-rated" bonds, which means they are regarded as investment grade by one rating agency and as below investment grade by another.

"We haven't had a need to issue debt to raise additional capital" since the 1988 issue, the spokesman said. Meanwhile, with interest rates low, Reliance is now exploring ways to refinance its outstanding high-yield debt, "and we think there'll be opportunity to do that," he said.

USF&G Corp. also has junk bonds outstanding, noted a spokeswoman. While originally issued as investment-grade bonds, the bonds issued by the Baltimore-based insurer fell below investment grade after management changes in 1990 (BI, Dec. 3, 1990). Such downgrades are known as "fallen angels."

"We plan to issue no debt until our ratings have been upgraded," the USF&G spokeswoman said.

Other insurers with outstand-

ing junk bonds include Fremont General Corp., which has a \$50 million junk bond issue dating back to October 1983 that it will retire this year, said Chief Financial Officer Wayne Bailey. The Los Angeles-based insurer has no plans to return to the junk bond market, he said. "It's too expensive."

Fremont General will find other means of meeting any capital needs, Mr. Bailey said.

New York-based Home Holdings Inc. has a total of \$79 million in outstanding junk bonds from two issues that it inherited by acquiring The Home Insurance Co. from AmBase Corp. (BI, Feb. 18, 1991). Home Holdings has no plans to return to the junk bond market, said Jan Eveland, chief financial officer.

Analysts say future junk bond issues by insurers are most likely to be done in conjunction with LBOs, which could become more frequent if consolidation occurs in the industry.

"The potential for additional LBOs certainly exists," and junk bonds are one way these could be financed, said Stan O'Neal, managing director in charge of high-yield bonds at Merrill Lynch.

But junk bonds are unlikely to be used by insurers as a means to raise capital, he said.

By and large, most insurance companies are not so highly leveraged that they fall into the junk bond category, Mr. O'Neal explained.

Merrill Lynch's Mr. Blanchard noted that an insurance company would have to have a low credit

rating to go into the more costly junk bond market, but must also be stable enough to provide the cash flow to pay off the debt.

A leveraged transaction is one circumstance in which you are likely to see both these factors emerge, as was the case with American Re, he said.

"They're a great company," said Mr. Blanchard, adding, "I think the success of American Re has more people looking at the prospect of doing insurance LBOs."

But he agreed with Mr. O'Neal that there are likely to be few insurance company issues outside the LBO market. "I think there are relatively few truly junky insurance companies," he said.

David Seifer, vp, with Donaldson, Lufkin & Jenrette Securities Corp. in New York, said junk bonds "might be a factor in acquisitions," but the insurance company investor wants high-yield bonds "to come off the balance sheet as soon as possible."

One factor hindering insurance companies' use of junk bonds is regulatory constraints. State insurance laws could inhibit holding companies from taking money as freely from their insurance company subsidiaries to service debt as could companies in other industries.

While this may be a detriment to the junk bond investor, it is definitely a benefit to the policyholder, said Mr. Wells of Bear, Stearns.

"The investors' risk is the policyholder's protection," he commented. **BI**

Managed care still plays small work comp role

By MICHAEL BRADFORD

DALLAS—While rising workers compensation medical costs are a top priority for many employers, only a handful have introduced elements of managed care in their workers comp programs.

The medical component of workers comp has grown to the point where 80% of employers believe it is the single greatest contributor to rising workers comp costs, a new survey by broker Johnson & Higgins indicates.

The survey, slated for release at the end of this month, also found that 45% of the respondents regard controlling workers comp medical costs as their "single highest priority," said David North, senior vp with the broker in Chicago.

However, he added at a J&H conference in Dallas last month, only 8.6% of the respondents said they are using some form of managed care to contain those costs.

"I think the dynamics are going to change significantly," particularly in light of health care reforms that are on the horizon from the Clinton administration, said Mr. North. "We're going to look at health care in new and different ways."

Managed care, already a prominent method of controlling medical costs in group health plans, is only beginning to play a role in keeping medical costs down in workers comp cases, agreed Arthur Lerner, a principal with the Washington law firm of Michaels & Wishner.

Mr. Lerner predicts that managed care will become widely used in workers comp cases, but he warned employers to be on the lookout for several obstacles that could slow attempts to apply managed care concepts.

The biggest difficulty in many states, Mr. Lerner pointed out, is structuring a managed provider network without violating state workers comp laws.

Under the laws in many states, workers compensation claimants must have a free choice of providers, he noted, which

Employers struggle to control medical costs while still complying with individual state laws

means employers cannot force injured workers to receive care from a network of providers.

Employers in some states have established "voluntary" PPOs for employees, Mr. Lerner said. Although they cannot use financial incentives to steer injured employees to network providers, employers can promote the networks in other ways, such as by touting the quality of the network's care.

These voluntary networks are successful in states where employees agree that the highest-quality medical care in their area is offered through the network, he observed.

Workers comp laws require that injured workers receive full coverage of medical expenses, meaning there is no room for a managed care program that includes deductibles or copayments, which are common in preferred provider arrangements used in group health care plans, said Mr. Lerner.

In addition, some employers are exploring so-called 24-hour coverage as a way to bring down workers compensation medical costs.

Twenty-four-hour coverage is designed to cover employees for all injuries and illnesses—whether or not they are work-related—under a single plan. While the development of insurance policies that would accomplish this is hindered by state regulations, some companies are finding ways to implement elements of 24-hour coverage, like centralized claims administration.

FHP Inc. of Costa Mesa, Calif., is a managed care company that implemented a quasi-24-hour coverage plan for its own workforce in 1988, and now also markets the concept to others, according to Edward Zutler, senior vp at FHP.

FHP's approach is to tie together the group health and workers comp medical programs of its clients, most of which are in California, by centralizing claims administration and introducing some group health managed care concepts to workers comp (BI, Sept. 28, 1992).

Mr. Zutler pointed out that California law does not allow a single insurance policy to provide both group health and workers comp coverage.

Therefore, FHP offers its clients an HMO arrangement for group health benefits and workers comp coverage that is underwritten by Reliance Insurance Co. FHP provides administrative services for both plans.

Three years after implementing its own program, FHP found its cost per claim had fallen, its rate of litigation was far below the state average and the number of claims per thousand employees had been down dramatically, according to Mr. Zutler.

That's when FHP decided to offer a 24-hour product to its clients.

"What it provides is coordination of some of the administrative services," Mr. Zutler explained.

And, one advantage to such an approach is that it avoids duplicate claim payments.

"There are physicians who will bill both the workers comp carrier and the benefits carrier on a claim because they don't know whether it's work-related or not," Mr. Zutler said.

The FHP plan also applies managed care concepts to workers comp cases, he explained.

An "industrial injury network" has been set up in lieu of the health maintenance organizations FHP offers for health benefits, he said. The network is composed of providers, including occupational therapy nurses and physicians, who are located

close to a client's worksites.

In addition, utilization review and case management techniques are used on every claim.

"I don't want to tell you that we've found the cure-all, because we haven't," said Mr. Zutler. "What we have done at FHP is take the first steps. The signposts look favorable. We know that we could literally sell billions of dollars of coverage if we had the capital and surplus to do it."

FHP will expand its offering soon with the purchase of Great States Insurance Co., which will give it an additional market for the workers comp component of the 24-hour program.

Another panelist agreed that workers compensation medical costs can be lowered because of the efficiencies in managing both workers comp and group health coverage under a single 24-hour coverage program.

Employers should pursue the use of managed care techniques in workers comp cases if state laws don't forbid it, said Susan Sauer, vp at Johnson & Higgins in Chicago.

"Try them," she urged employers. "I think you'll find that a state that is silent in its statutes will allow you to take the initiative."

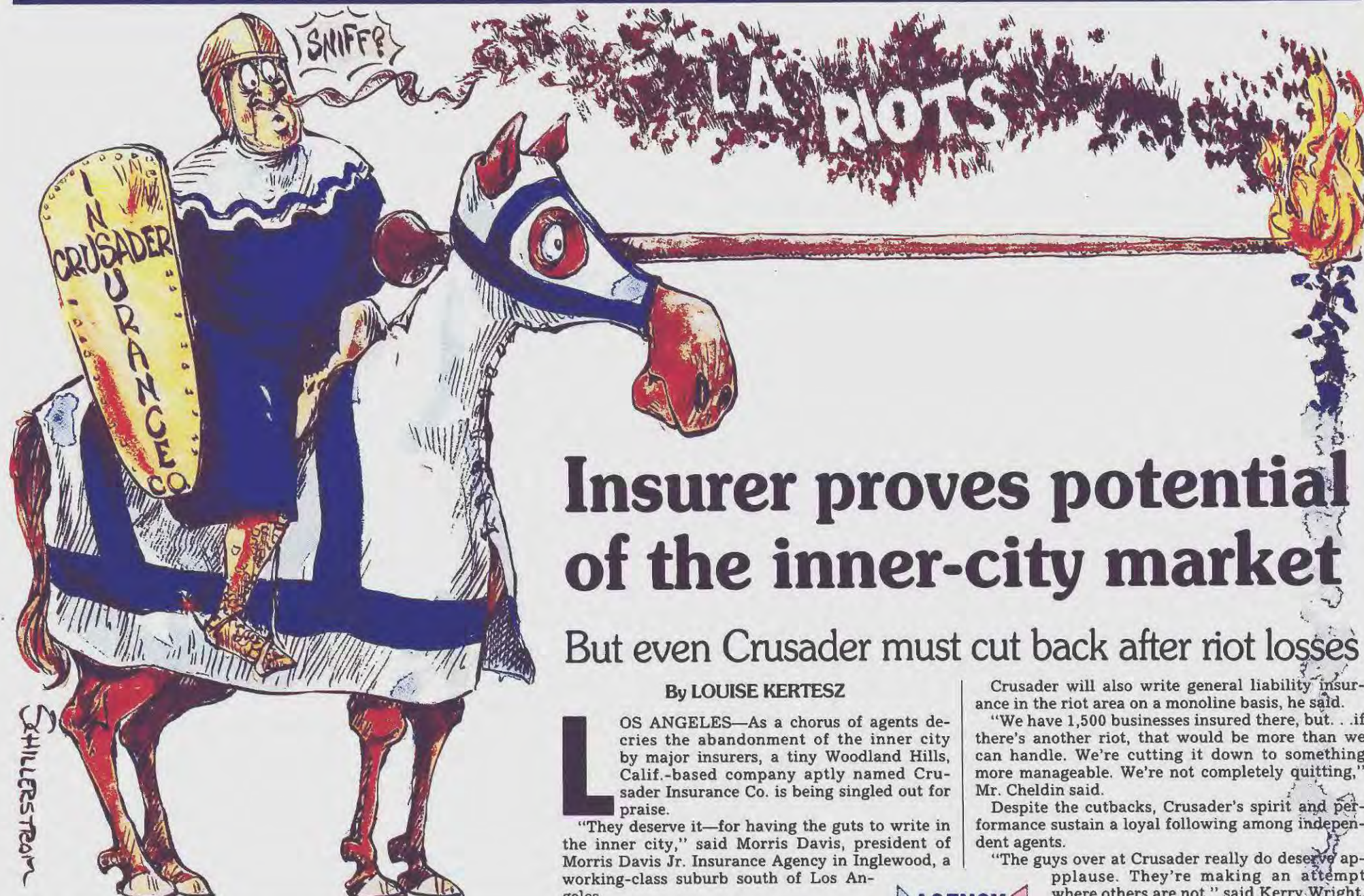
Ms. Sauer said one approach that could work for many corporations is to have a large insurer provide coverage for both group health and workers comp benefits "and integrate the two programs from a care standpoint" using one data base to manage cases.

"The difficult thing is to find one data base that can cover both sides of the house," she acknowledged, but one case manager could be used to handle all claims.

That case manager should have a good knowledge of the corporation, how it operates and the best way to return employees to work, she noted. "There is definitely (the opportunity for) success through an integration of two programs." **BI**

Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers



Insurer proves potential of the inner-city market

But even Crusader must cut back after riot losses

By LOUISE KERTESZ

LOS ANGELES—As a chorus of agents decries the abandonment of the inner city by major insurers, a tiny Woodland Hills, Calif.-based company aptly named Crusader Insurance Co. is being singled out for praise.

"They deserve it—for having the guts to write in the inner city," said Morris Davis, president of Morris Davis Jr. Insurance Agency in Inglewood, a working-class suburb south of Los Angeles.

Following the riots in Los Angeles last April, agents decried the lack of markets available to inner-city businesses (A/BT, July 6, 1992).

But Crusader "basically has proven that if you are really interested in writing in the inner city, you can turn a profit. It's not impossible, it's not what traditionally has been thought of as a losing proposition that has to be subsidized. They have proven the market wrong," said Javier Rodriguez, president of the Hispanic Agents & Brokers Assn. and of Rodriguez Insurance Agency in South Gate, near Los Angeles.

"We have used them in countless situations. Their service is good, the turnaround is great, it's almost like having a preferred market for the inner city. They've done a splendid job and the industry should take note," Mr. Rodriguez said.

Crusader, which grew from \$1.8 million in capital and surplus in 1985 to \$17.4 million in 1992, is the largest unit of Unico American Corp., a holding company in Woodland Hills.

But Crusader has had to pull back from the inner city as a result of riot-related losses. The insurer sustained \$21.5 million in losses, reduced to \$10.5 million after reinsurance and tax write-offs, said Cary Cheldin, executive vp. And National Reinsurance Co., which reinsures Crusader, loaned the insurer \$2 million to reduce surplus.

"For the time being," Crusader is cutting 75% of its property policies—which include coverage for damage caused by civil commotion—in the riot area through non-renewals, Mr. Cheldin said. It will maintain 25% of its property coverage with riot exposure, and will write some additional property coverage with an exclusion for riot damage.

Crusader will also write general liability insurance in the riot area on a monoline basis, he said.

"We have 1,500 businesses insured there, but... if there's another riot, that would be more than we can handle. We're cutting it down to something more manageable. We're not completely quitting," Mr. Cheldin said.

Despite the cutbacks, Crusader's spirit and performance sustain a loyal following among independent agents.

"The guys over at Crusader really do deserve applause. They're making an attempt where others are not," said Kerry Wright, owner of Wright-Way Financial Insurance Services in Westwood, an affluent area of Los Angeles.

Mr. Wright recently moved his agency from the inner city because he could not get appointments with major insurers with his previous location, he said.

"Just like their name—they're crusaders. They came in here and stuck their necks out where nobody else did. They gave agents a market with no volume requirements and no strenuous qualifications like most big companies make," Mr. Davis said. "Hartford, Fireman's Fund, Mercury Casualty and CNA—all these people have so many requirements, you don't qualify no matter what you do. Three (inner-city agents) tried to pool our volume to get to CNA, but once we met that volume requirement, we didn't meet other requirements."

Mr. Davis and other independent agents say the solution for inner-city agents is "an open broker system where any broker would submit any piece of qualified business to any company."

"We always have offered our products and services to any (broker) in good legal standing that possesses a proper license to sell insurance in California. We don't qualify our producers other than that," said Mr. Cheldin.

"We also work hard to provide the products that agents ask us to. That includes businesses with no prior insurance or those in low-income communities," he added.

Mr. Kerry pointed out that Crusader's losses as a result of the Los Angeles riots were relatively large compared to losses by much bigger insurers. For example, Farmers Insurance Group in Los Angeles

Continued on page 16B

Hawaiian agents search for cover following Iniki

By MICHAEL BRADFORD

HONOLULU—The rebuilding after Hurricane Iniki swept through last year will one day be complete, but the storm's damage to Hawaii's insurance landscape may not be so easily repaired.

Insurers leery of a repeat of the storm that caused \$1.6 billion in insured damage mostly on Kauai last fall are abandoning the homeowners market, leaving policyholders, agents and brokers high and dry (BI, Sept. 28, 1992).

The market for homeowners insurance began drying up in January, with high-priced surplus lines insurers and a state facility remaining virtually the last resort for buyers.

State Farm Group, the state's largest homeowners insurer with 16.5% of the market, continues to write coverage but with restrictions identical to those it placed on agents in Florida after Hurricane Andrew hit (BI, Oct. 19).

Agents' pleas to mainland underwriters to enter the market have so far fallen mostly on deaf ears.

Continued on page 16D

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Agent/Broker Topics

Hawaiian market

Continued from page 16A

However, a plan to create a pool to fund the hurricane portion of homeowners risks is now before state lawmakers. If approved, this would take the exposure away from private insurers, which may then reconsider entering the market.

"We have an availability problem," Hawaii Insurance Commissioner Linda Chu Takayama said in a sweeping understatement. "Homeowners insurance is no longer easy to get, and what's out there is a lot more than what homeowners are accustomed to paying."

And if problems in the homeowners market aren't bad enough, the crisis may be spreading.

"I've heard from some agents that it may be filtering into the commercial lines market," said Terry Silva, executive vp of the Hawaii Independent Insurance Agents Assn. "Especially in smaller commercial lines risks."

Ms. Silva said there are reports that insurers are "becoming more strict and more selective" in the types of commercial risks they are writing.

"It is affecting the commercial property market," said Christopher G. Oda, vp with Alexander of Hawaii, a Honolulu subsidiary of Alexander & Alexander Inc. "There are a lot of wind deductibles or wind exclusions on renewals and new business. There is some major re-underwriting going on."

Ms. Takayama said the insurance community is working hard to attract personal lines insurers to Hawaii. The Insurance Department will quickly approve applications to enter the market if they meet state requirements, she noted, though applications are not flooding in.

"Our agents have been very aggressively pursuing the mainland markets," said Ms. Silva. "We've been visiting with them, encouraging them, telling them we will do what we can to make Hawaii a more attractive place to do business."

But so far, those efforts have not been fruitful. "I've heard of one member who may be close to closing a deal with a market," she said, declining to name the insurer.

Agents and policyholders are finding themselves with an "any-port-in-the-storm mentality," said Jim Cavanah, vp of Cavanah & As-

Iniki's fallout

Five of the nine largest homeowners insurers in Hawaii (in bold) have restricted their coverage or dropped it entirely since the hurricane. Market share is based on 1991 premiums.

Insurer	Market share
State Farm	16.5%
Island Insurance Group	13.6
Hawaiian Insurance Group	11.6
Continental	11.3
Allstate	9.8
ITT/Hartford	8.4
Transamerica	7.5
USAA	6.6
Fireman's Fund	5.0

Source: A.M. Best Co.

GRAPHIC BY JOHN J. BOHORQUEZ

sociates Inc. in Honolulu and president of the HIIAA. "We're really searching for markets to come here."

"We've been getting some feelers from carriers, but only on a non-admitted basis," said Mr. Oda of Alexander of Hawaii. "That makes us very wary because they're not subject to the guaranty fund."

Mr. Cavanah said it's hard to blame insurers for leaving the market when taking a look at the decisions underwriters must make. Many not only are absorbing losses from the hurricane but also face rising reinsurance costs if they stay.

"I've been working with a couple of companies trying to get them in," he said. "I've seen their calculations. They are making business decisions, and you can't blame them for protecting their companies."

Ms. Silva agreed that insurers are finding reinsurance "a major problem" with regard to Hawaii homeowners risks. "When they enter a new market, they want to make sure they can get enough reinsurance."

Insurers that left the market have all given policyholders adequate notice according to regulations, Ms. Takayama said.

Hawaii's problems reached a critical point on Feb. 19 when coverage for policyholders of Hawaiian Insurance Group's insolvent subsidiaries was canceled. The group was the third-largest underwriter of homeowners coverage in the state with 11.6% of the market, according to A.M. Best Co.

Hawaiian Insurance Group policyholders joined thousands of others whose coverage was not renewed by insurers leaving the state.

"In the meantime, there are no new carriers and nobody else wants to take on new values," Mr. Cavanah said. New entrants in the market don't want to pay high reinsurance prices, and "the companies that remain are in the same boat. They're not taking any new business."

For agents, "the end result is if we don't have a company policy to sell, we can't sell a policy. So we can't make a buck," he added.

Before the cancellation of Hawaiian Insurance Group's policies, several insurers had already decided to leave the market, or at least institute restrictions.

For example, State Farm's new guidelines for its agents mirror the changes the insurer made in Florida following Hurricane Andrew.

The restrictions, which apply to
Continued on page 16F

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Agent/Broker Topics

Hawaiian market

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new business, call for agents to write no more than \$750,000 each per month in personal lines coverage for structures and contents, and no more than \$1 million per month in commercial property coverage for structures and their contents.

No new personal or commercial lines policies will be written on a guaranteed replacement-cost basis by State Farm agents.

In January, Pacific Insurance Co. Ltd., a subsidiary of ITT Hartford Insurance Group, announced that it

will stop writing new and renewal policies in Hawaii. A letter to Ms. Takayama concluded that Pacific Insurance's "aggregate exposure was far in excess of (its) previously assessed hurricane potential."

The insurer, which wrote about 18,000 residential policies with premiums of about \$5.2 million, was also finding it difficult to obtain adequate reinsurance, said Ron G. Hashimoto, Pacific's president and chief operating officer.

Mr. Hashimoto said the insurer "must act responsibly to protect our company's long-term financial strength against potentially very significant losses on the islands."

First Insurance Co. of Hawaii Ltd., a subsidiary of Continental Insurance Cos. and the fourth-largest homeowners insurer with 11.3% of the market, exited Hawaii on Feb. 1, leaving 16,000 policyholders to find replacement coverage.

In addition, Allstate Insurance Co., which held 9.8% of the market, has stopped writing new Hawaiian homeowners policies at least until April. Allstate's decision was reached after a flood of new policy applications began pouring in as insurers left the market.

"We need to evaluate what's hap-

pening in the marketplace and its impact on our customers," said Michael Clark, Allstate's regional vp in Seattle. The insurer began writing a "disproportionate amount of new homeowners policies" at the beginning of the year and began to worry about a strain on its ability to service existing accounts, he said.

Liberty Mutual Insurance Co., which held 2.9% of the homeowners market, found itself in a similar position and decided in February to stop writing new policies except for its existing customers. The decision was made solely because "we were unable to handle our existing customers and their needs," said a spokeswoman, adding it was not due to the hurricane losses. "In the first four weeks of 1993, we had a 400% increase in new applications over the same period in 1992."

Agents and brokers in Hawaii now find themselves turning to the state's Fair Access to Insurance Requirements plan, a facility established in 1991 to write property coverage in areas on the island of Hawaii threatened by lava.

Expansion of the facility means it now accepts homeowners policies statewide as an insurer of last resort. The cost of up to \$250,000 worth of

coverage through the facility is roughly three times the standard cost of homeowners insurance.

FAIR plans are pools maintained by private insurers and reinsured by the U.S. government.

Ms. Takayama and others also are working on a legislative solution to the crisis. She is proposing the state create a pool that would insure hurricane exposures, freeing the private market to write other types of homeowners coverages.

The pool would be funded by premiums and a 2% assessment against insurers' annual premiums.

Additional funding for the facility would come from other sources, she said, including an increase in the state's conveyance tax on property transfer and an increase in the franchise tax paid by mortgage lenders.

Ms. Takayama pointed out that even if the pool is approved, it will likely be the end of the year before it begins operating. **[B]**

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New York market woes feared by agent group

SYRACUSE, N.Y.—The Independent Insurance Agents Assn. of New York has written a letter to insurers in the hopes of averting a crisis in the state's homeowners insurance market like the capacity shortage in Hawaii (see story, page 16A).

But despite the potentially severe market ills, the agents also want to avoid any legislative cures.

Among the association's concerns is the move by some insurers to restrict the amount of waterfront coverage they will write on Long Island and other parts of New York in the wake of losses from last year's heavy storms, according to Walter B. Rose Jr., president of the IIAANY.

Some insurers have not renewed homeowners coverage within 1,500 feet of shorelines, have reduced agent commissions in the hopes that agents will move business to other companies and have rewritten policies according to geographic location, Mr. Rose charges.

In a letter to senior executives

of insurers that operate in New York, Mr. Rose said such moves "threaten to cause long-term damage. We are concerned over potential availability of property insurance in certain downstate areas."

Mr. Rose said agents also are concerned that any new regulation or legislation to fend off a crisis could hurt working relationships among agents, insurers and regulators. "We are deeply concerned over the financial viability of our members' businesses," he wrote.

If lawmakers must intervene to find a cure for an insurance availability problem, the result could be "an economic or punitive blow from which our industry will not soon recover," the letter continued.

Mr. Rose acknowledged in an interview that "most major players" are not restricting writings. The New York Insurance Department is conducting a survey to determine which insurers have instituted underwriting restrictions.

—By Michael Bradford

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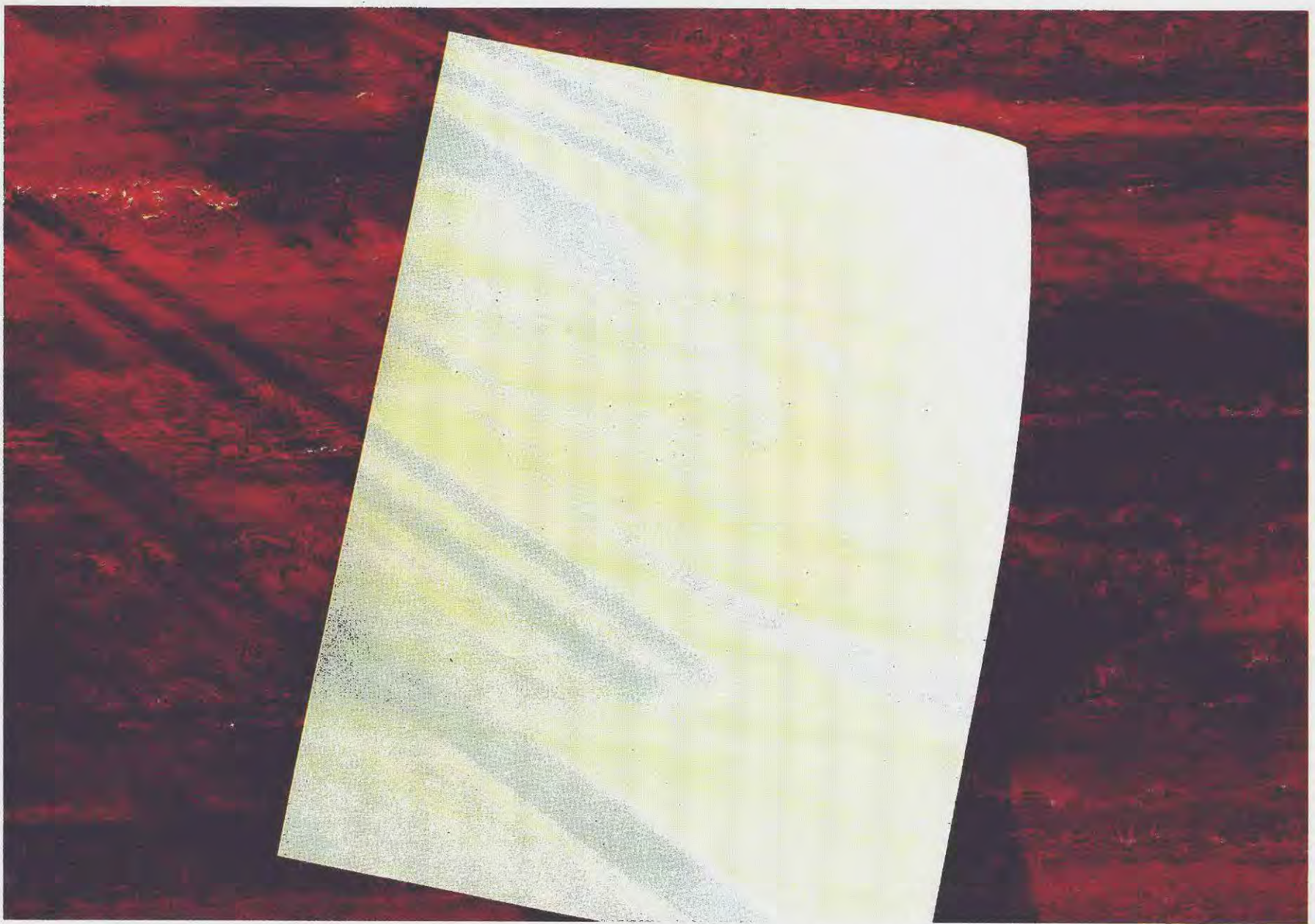
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Agent/Broker Topics

And now, a word from our counsel

Ads by lawyers seen as spurring lawsuits, claims by public

By MARK A. HOFMANN

OAK BROOK, Ill.—A growing proportion of consumers think attorney advertising is increasing the number of lawsuits.

In addition, almost as many consumers believe that such advertising has helped raise their auto liability insurance costs.

The findings appear in the Oak Brook, Ill.-based Insurance Research Council's "Public Attitude Monitor 1992," the most recent in an ongoing series of annual reports measuring public opinion on insurance-related issues.

The Roper Organization Inc. conducted the study on behalf of the IRC, a non-profit research group supported by the property/casualty insurance industry. Roper interviewed 1,976 adults during a one-week period beginning June 6, 1992.

Seventy-eight percent of the respondents to the newest survey reported having seen or heard attorney advertisements, an increase from 72% in 1989, the last year the question was asked.

Of those who said they had been exposed to lawyer advertising, 78% said they thought advertising has increased the number of liability claims and lawsuits, compared with 73% in 1989. Two percent thought

advertising had decreased the number of lawsuits, a doubling of 1989's 1% response. Only 13% thought such advertising had no effect on the number of lawsuits, down from 17% four years earlier.

Seven percent didn't know or had no opinion on the impact of lawyer advertising on the number of lawsuits, a slight drop from 1989's 9%.

Attorney advertising also has increased the cost of auto insurance, according to respondents. Seven out of 10 of those who had been exposed to such advertising said it helped increase auto insurance rates, compared with 64% in 1989. Two percent thought lawyer advertising had cut auto insurance rates, compared with 1% in 1989. Seventeen percent thought such advertising had no impact, a decline from 23% in 1989.

Ten percent of last year's respondents and 13% of the 1989 sample offered no opinion.

The survey also found that about 8% of respondents think it is morally acceptable for someone injured at home to claim the injury is work-related so he or she can collect workers compensation benefits. And nearly 20% said a worker who still feels some pain should stay at home and collect workers comp benefits, even if the doctor says the injured person can return to work.

The acceptance of fraud to obtain benefits diminishes to 4% when the perpetrator "knowingly" cooperates with lawyers, doctors or chiropractors who file false and exaggerated claims to tap into insurance money. A similar percentage found it acceptable for someone collecting workers comp benefits to work at another job while receiving the payments.

Ten percent of the respondents also said that claiming disability benefits "in order to take a month or so off work because you are feeling 'stressed out'" is an acceptable practice.

Four percent said they thought it acceptable for someone to claim reimbursement under an employer-provided disability insurance policy for loss of wages that had already been reimbursed by the employer's workers comp insurer. Also, 3% found it acceptable for a worker who has been laid off or who is facing a layoff to fraudulently file a disability claim.

In addition to determining moral attitudes, the survey also attempted to uncover the public's awareness of earthquake threat and attitude toward earthquake insurance.

Not surprisingly, awareness of the earthquake peril was far more acute in the western United States than in other sections of the country, even though each region has some earthquake exposure.

Nearly nine out of 10 Westerners—89%—were aware they live in a region where a damaging earthquake could occur, but the awareness dropped dramatically among residents of other regions.

Only 27% of the Midwesterners were aware they live in an earthquake-prone zone, even though the New Madrid Fault—south of the Great Earthquake of 1811-12—runs along the Mississippi and Ohio rivers. Among residents of the East and South, awareness fell to 16%.

Only 23% of the respondents who said they live in an earthquake-prone area said they had a special earthquake insurance endorsement to their homeowners policy. Nine percent of the total sample reported

they had such coverage.

When asked why they did not carry it, 36% of all respondents said they didn't need it, 36% said they don't live in an earthquake zone, 11% said they never heard of such coverage and 8% said earthquake insurance costs too much.

Other reasons given for not buying earthquake insurance included: simply having not gotten around to

doing so; believing earthquake damage was covered under existing homeowners policies; and believing the large deductibles contained in earthquake policies make such coverage an "unattractive buy for the money."

Public Attitude Monitor 1992 costs \$5. It can be ordered from the Insurance Research Council, 1200 Harger Road, Suite 300, Oak Brook, Ill. 60521; 708-572-1177.

Alabama judge OKs broker's surplus cover

MONTGOMERY, Ala.—Arthur J. Gallagher can continue offering and selling surplus lines poultry house insurance in Alabama, an appellate judge ruled late last month.

The Alabama insurance commissioner previously ruled that the broker was in violation of the state's surplus lines statute because there were three other licensed, authorized insurance companies offering poultry house insurance coverage in the state.

The Alabama surplus lines statute states that "if certain insurance coverage cannot be procured on terms acceptable to the insureds from authorized insurers, such coverages, designated 'surplus lines,' may then be procured from unauthorized insurers."

The insurer in question must prove, among other things, that it has made a "diligent effort" to place the insurance with authorized insurers.

Appellate Judge L. Charles Wright found that Gallagher had complied with the requirements of the Alabama surplus lines law.

In a written opinion, Judge Wright additionally found the commissioner's previous ruling

A/BT Briefs

was a "harsh interpretation" of the statute.

Under the prior decision, "an insured would be required to obtain a particular insurance coverage from an admitted insurer, even if the same type of coverage is available from a surplus lines carrier and is more acceptable and advantageous to the insured," Judge Wright wrote.

BIPAR cancels plan to meet in U.S. in '93

WASHINGTON—The international insurance producers' association, BIPAR, has canceled its scheduled meeting this year in the United States.

The association did not say why.

The meeting, which was scheduled for June 29-July 2 in Washington, D.C., would have been the first BIPAR meeting held in this country.

According to the National Assn. of Casualty & Surety Agents, host of the meeting, BIPAR officials said they hope to reschedule the meeting in 1994 in the United States. **BI**

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Rural health care

Continued from page 3

Other elements of the managed competition concept include collecting and reporting outcomes data, limiting the amount of tax-deductible employer contributions to employee health benefits and requiring insurers to community rate policyholders, though some risk adjustments would be permissible.

Critics of the concept say small urban areas and rural communities do not have large enough populations to support enough providers to create competition based on price and quality.

For example, the authors of the recent study sponsored by the federal Agency for Health Care Policy and Research said that a population of at least 180,000 is necessary to support three health plans that share tertiary care facilities and some specialists (BI, Feb. 1).

But, the Jackson Hole Group maintains that the managed competition concept—albeit an altered version of it—can work in rural areas.

"Although strict managed competition, as based on comprehensive organized delivery systems competing on the basis of cost and quality, does not apply to sparsely populated areas, the basic institutions of managed competition... are still appropriate for sparsely populated areas," the Jackson Hole Group says in its draft paper.

For example, AHPs in big cities would combine the services of primary health care providers and specialists with health insurers. These organizations would likely be vertically integrated, but they could take several forms, the draft points out.

But, the Jackson Hole Group says that competition in many rural areas may instead occur among small primary care facilities that will be either branch offices of urban AHPs or independent AHPs that contract with other providers for specialized care.

In areas with few doctors, physicians could contract with multiple AHPs, which would compete for business by offering services like referral networks and traveling specialists, as well as on the basis of quality and cost.

"Rural AHPs may look a lot more like primary care clinics," a Jackson Hole Group spokeswoman said. "Managed competition doesn't dictate any strict structure for AHPs."

Therefore, "Although a town of 15,000 could not support three comprehensive AHPs, it could support three competing primary care facilities," the draft says.

AHPs would be attracted to rural areas by the specter of business from health care purchasers organized by regional AHP authorities and by fair rates of Medicare and Medicaid reimbursement, the draft says. These authorities would be created by a National Health Board.

"Competition will occur as AHPs attempt to expand market share and rural providers band together to form AHPs," the draft says.

When AHPs balk at servicing an area because of high fixed costs per capita, regional authorities could offer them two incentives, the Jackson Hole Group says: government subsidies and exclusive franchise agreements.

Subsidies, which the Jackson Hole Group prefers, would work best when there is a sufficient health care infrastructure in place. AHPs then would not have to make a large capital investment to set up operations in the area, according to the draft.

And, a large infrastructure is not

necessary to deliver health care in rural areas through AHPs, the draft says. "Since the key hospitals are already in place, increases in the number of primary care physicians and better systems of communication and organization are the needed improvements. In most cases, the infrastructure would amount to a few primary care offices, linked to an established urban center.

"Therefore, subsidies alone, without the exclusive franchise, should be enough to attract AHPs to most markets."

The communication improvements that would be necessary involve how primary care physicians would arrange phone and live consultations with specialists, the Jackson Hole Group spokeswoman explained.

In more remote rural areas with very small populations and an insufficient infrastructure, rural

authorities may have to offer providers the additional incentive of an exclusive franchise for a significant period, the draft says. The AHPs would set prices with the approval of the HPPC.

These agreements also could be

tions, HPPCs in rural areas would assume "exceptional monitoring and regulating functions" over AHPs, the draft says. HPPCs would be given authority to take action against AHPs—like reducing subsidies or canceling exclusive-

by the federal health care policy agency.

A key question involves creating competition among specialists in rural areas, explained Dr. David C. Goodman, an assistant professor of pediatrics at the Dartmouth/Hitchcock Medical Center in Lebanon, N.H.

Noting that specialty services dominate health care costs, Dr. Goodman said rural areas often are adjacent to small urban areas that also cannot support competing specialty services.

"It's just hard to understand how these competitive environments would evolve in smaller urban areas" and rural areas, he said.

But, Dr. Goodman said the managed competition concept should be tested. Testing, though, should be conducted on a small scale before the managed competition is implemented nationwide, he suggested. **BI**

'Although strict managed competition... does not apply to sparsely populated areas, the basic institutions of managed competition... are still appropriate for sparsely populated areas,' says the Jackson Hole Group.

awarded through competitive bidding. "Bidding AHPs would agree to charge certain premiums in exchange for a given amount of governmental assistance," the draft says.

In addition to its normal func-

provider agreements—that do not deliver affordable quality health care.

But this modified version of the managed competition concept still does not answer all questions for a co-author of the study sponsored

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FOR THE BEST IN LIFE — AND HEALTH

**ITT HARTFORD**

Avoid the exclusions

By Richard Levy

POLLUTION EXCLUSIONS in the standard commercial general liability policy have replaced the old "sudden and accidental" exclusion. Two versions of them are presented in the accompanying boxes. It is commonly believed that these exclusions are absolute and preclude coverage for pollution. This is not true. A more accurate statement is that the newer exclusions need not bar coverage in many circumstances.

So far, the majority of the decisions concerning these exclusions have gone against the policyholders. But to judge from the opinions, many arguments that favor policyholders were not presented to the courts. Following are 10 arguments for avoiding these exclusions. All are supported by cases interpreting insurance policies or by the language or statements of the Insurance Services Office itself. With some arguments there are cases in opposition as well as in support.

- The renewal rule.

An insurer that renews a policy without informing the policyholder that the renewal policy will have narrower coverage than the current policy may not subsequently refuse to pay claims on the grounds of the narrower coverage. Rather, the insurer must provide the same coverage as in the current policy. Thus, if you were not told before you bought the policy with a new pollution exclusion that it was narrower in coverage than the previous version, you have a good argument for avoiding the new version.

- The standard pollution exclusion of 1985 was intended by ISO to be read more narrowly than it was written.

When the Texas State Board of Insurance held a public hearing in October 1985 on whether to approve the commercial general liability policy, one of the commissioners opined that the pollution exclusion was too broadly written. An insurance company official appearing on behalf of the Insurance Services Office agreed, explaining that ISO wanted to use narrower language but found itself incapable of drafting it. He told the commissioner that no one should read the exclusion as written: It was "overdrafted" (see box, page 20).

The explanation by ISO is an opening for *interpreting* the exclusion, even for an argument of ambiguity—at least in those cases that are analogous to the vp's explanation. Of course the universal rule is that ambiguities in insurance are interpreted against the insurers.

- Is it a "pollutant"? Does the exclusion consume the policy?

Decisions favoring policyholders in cases involving new pollution exclusions have mainly held that the substance at issue is not a pollutant, or the risk of pollution was so much a part of the business of the policyholder that, if the exclusion were upheld as interpreted by the insurer, the policy would be illusory.

In the exclusion, "pollutant" is defined, in brief, as "irritant" or "contaminant." The following explanation by a U.S. District Court in Kansas makes an excellent point:

"The terms 'irritant' and 'contaminant,' however, cannot be read in isolation, but must be construed as substances generally recognized as polluting the environment. In other words, a 'pollutant' is not merely any substance that may cause harm to the 'egg shell plaintiff,' but rather it is a toxic or particularly harmful material which is recognized as such in industry or by governmental regulators." *Westchester Fire Insurance Co. vs. City of Pittsburg, Kansas*, 768 F. Supp. 1463 (D. Kan. 1991).

In that case, the court held that the pesticide malathion, which had allegedly caused bodily injury to three persons, was not an "irritant" or "contaminant."

In general, when one begins to concentrate on the meaning of pollutant—When is a substance a pollutant? Where? Under what circumstances? Under what law?—much room opens up for imagination and for development of arguments against the exclusion. Such arguments cannot be presented here because should the insurers think them as strong as I do, they can negate

Pollution losses may be covered

One common variation on the standard ISO pollution exclusion

This policy does not apply to Personal Injury or Property Damage arising out of the discharge, dispersal, release, escape of seepage of oil, petroleum substances or derivatives (including any oil refuse or oil mixed with wastes), smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste material or other irritants, contaminants or pollutants into or upon land, the atmosphere or any watercourse, body of water, bog, marsh, swamp or wetland, whether or not such discharge, dispersal, release or escape is sudden and accidental, or gradual and accidental.

them by properly worded endorsements to their policies. Let me just suggest a focus on all the factors that bear on the meaning of "pollutant."

The second theme is the place of the risk of pollution in the scope of risk of the business. If pollution is a major risk or a common risk, then you have an argument that at least these are not excluded.

- The claims of "indemnities" are not excluded.

Often your policy will have an exclusion that refers to an "indemnitee" or to a person indemnified. For example, exclusion B of the commercial general liability policy excludes liability assumed in a contract or agreement unless the contract or agreement is an "insured contract." The definition of an insured contract excludes, among other things, any clause that indemnifies any person for damage by fire to premises rented to the policyholder (section VI-definition 6). In other words, even with an "insured contract,"

indemnification of another for fire damage to rented premises is expressly excluded. But the pollution exclusion has no reference to an "indemnitee" or to a person indemnified. One common sense interpretation is drawn from the absence of these references.

Suppose a series of exclusions read this way:

A-You are excluded under circumstance 1. B-You are excluded under circumstance 2. C-You are excluded under circumstance 3. D-You and your spouse are excluded under circumstance 4.

The common-sense interpretation of this series is that your spouse is not excluded under the first three circumstances but only under the fourth. This common-sense view is supported by cases.

Therefore, if your landlord or some other person whom you have promised to hold harmless makes a claim against you for pollution, that claim in some courts should not be excluded by the pollution exclusion.

Even if the policy does not use "indemnitee" or equivalent language, at least one court, the 9th U.S. Circuit Court of Appeals, has held that claims made by an indemnitee are covered unless the relevant exclusion expressly applies to indemnitees.

- When the pollution is caused by a third party.

A few courts may find the exclusion ambiguous regarding whether it applies when a third party is the cause of the pollution for which you are held liable. The reason for finding it ambiguous is the exclusion makes no mention of third parties. The ambiguity is intensified by comparison of the exclusion to those parts of the policy that expressly refer to third parties acting for the policyholder.

One example is exclusion m. (2), which expressly excludes "anyone acting on your behalf." Such examples would be presented to the court under the principle of interpretation described in the fourth point, above.

In addition, an analogy can be drawn from the cases concerning the sistership exclusion that excludes coverage for the cost of withdrawing from the market the policyholder's products because they are suspected to be defective (exclusion n. in the most recent commercial general liability policy). The versions of this exclusion in the comprehensive general liability form of 1973 did not state that the exclusion applied to those besides the

Continued on page 20

Standard pollution exclusion of 1985 with additions of 1988 Additions are in italics, deletions are in parentheses.

f.(1) "Bodily injury" or "property damage" arising out of the actual, alleged or threatened discharge, dispersal, *seepage, migration*, release or escape of pollutants:

(a) At or from (any) premises, *site or location which is or was at any time* (you) owned, or occupied by, or rented or loaned to, any insured;

(b) At or from any premises, site or location *which is or was at any time* used by or for (you) *any insured* or others for the handling, storage, disposal, processing or treatment of waste;

(c) Which are *or were* at any time transported, handled, stored, treated, disposed of, or any person or organization for whom you may be legally responsible; or

(d) At or from any premises, site or location on which (you) *any insured* or any contractors or subcontractors working directly or indirectly on (your) *any insured's* behalf are performing operations:

(i) if the pollutants are brought on or to the premises, site or location in connection with such operations *by such insured, contractor or subcontractor*; or

(ii) if the operations are to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, *or in any way respond*

to, or assess the effects of (the) pollutants.

Subparagraphs (a) and (d)(i) do not apply to "bodily injury" or "property damage" arising out of heat, smoke or fumes from a hostile fire.

As used in this exclusion, a hostile fire means one which becomes uncontrollable or breaks out from where it was intended to be.

(2) Any loss, cost, or expense arising out of any:

(a) (governmental direction or) request, demand or order that (you) *any insured* or others test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, *or in any way respond to, or assess the effects of* pollutants; or

(b) *claim or suit by or on behalf of a governmental authority for damages because of testing for, monitoring, cleaning up, removing, containing, treating, detoxifying or neutralizing or in any way responding to or assessing the effects of pollutants.*

Pollutants means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

Pollution exclusions

Continued from page 19
policyholder (exclusion (p)).

As a result, several courts held that the exclusion of 1973 did not apply when someone else, such as a distributor, withdrew the products and then sued the manufacturer for reimbursement: the manufacturer's policy excluded only the manufacturer's expenses of withdrawal, not the distributor's. Although the exclusion in the commercial general liability policy now applies to expenses incurred by the policyholder "or others," the cases concerning the 1973 version remain good analogies for the previous argument.

- Some circumstances are plainly not excluded.

Under the plain English meaning of the new standard pollution exclusion, pollution at sites that are not owned, rented, or occupied by the policyholder, and which are not waste sites, is not excluded. This, indeed, is what ISO itself has said.

In addition, paragraph two of the exclusion of 1985, excluding expenses incurred by the policyholder pursuant to governmental directions and requests to remediate, does not exclude your reimbursement of expenses incurred by the government for remediation that it has performed. Thus, if you can agree with the relevant agency that it should clean up and then request reimbursement, your chances for coverage are better.

One should give due weight to the reference in the exclusion to "governmental" direction or request. In my experience, governmental agencies are lax in proper delegations of authority. I have seen instances where the chain of delegations that should extend from the highest official to the employee who communicates to you stops before reaching him, does not exist at all, or gives that employee less authority than he or she purports to have. Is a direction or request from one not authorized to issue it "governmental?"

Even if the direction or request is properly authorized, under the doctrine of concurrent causation you still may not be barred. Under that doctrine, if there are two or more causes of a loss and only one is excluded, the policy covers the loss nonetheless. If you would have cleaned up the pollution anyway, even if the government had never issued a directive or request, then your independent motivation would be a concurrent cause of the remediation. Because it is not excluded by the pollution exclusion, the cost of remediation would be covered.

- ISO's revisions may be used against it.

In 1988, ISO revised its standard pollution exclusion of 1985 by adding language to what was already there. Thus it added "migration" and "seepage" to "discharge, dispersal, release, and escape" of pollutants. It added "order" to governmental direction or request. And it added reimbursement to the government as an excluded cost in paragraph 2 (see box on page 19). Some courts will read these additions as admissions that the original version of 1985 was not intended to extend to where the new language reaches. By this principle, the migration or seepage of pollutants offsite, as distinguished from the discharge, dispersal, release and escape (which, upon close examination, will be seen to have particular connotations), should be covered, and governmental orders, which are different from directions or requests, are also not excluded.

- The drafting history may help.

The drafting history of the new exclusions, when it is finally extracted from ISO's grip, promises more aid on your behalf. I deduce this promise from the very power of ISO's resistance to revealing this history in

Transcript of Texas CGL hearing

The following is from an October 1985 hearing before the Texas State Board of Insurance to gain approval for the new commercial general liability policy in the state. Wade Harrel was a director with Liberty Mutual Insurance Co. and worked with the Insurance Services Organization committee that drafted the CGL policy form. David Thornberry was a member of the State Board of Insurance; and Ed Rinehimer was an associate director with Travelers Corp.

Mr. Thornberry: Let me ask the next question, and I may have already anticipated the answer. In both the claims-made and the occurrence forms that have been filed on the pollution exemption under just the original commercial general liability coverage exclusion 2 (f) on pollution, bodily injury or property damage arising out of the actual alleged or threatened discharge, dispersal, release or escape of pollutants, then are listed at different places that may go to different locations. The definition of pollutants is, "Pollutants means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste." Waste includes certain other things.

My reading of that language is so broad that the example I have been given in the past—the grocery store where the alkali or acid spills on the floor, either through negligent failure to clean it up or negligence, the child walks in and falls in it, is disfigured. My reading of that exclusion is that pollution is excluded from the policy and there is no coverage. And that I guess is the correct reading.

Mr. Harrel: That is a reading, yeah. It can be read that way, just as today's policy the pollution exclusion can be read in context with the rest of the policy to exclude any products liability claim. You can read today's CGL policy and say that if you insure a tank manufacturer whose tank is put in the ground and leaks, that that leak is a pollution loss. And the pollution exclusion if you read it literally would deny coverage for that. I don't know anybody that's reading the policy that way, and I think you can read the new policy just the way you read it. But our insureds would be at the State Board—someone said yesterday—quicker than a New York minute if, in fact, every time a bottle of Clorox fell off a shelf at a grocery store and we denied the claim because it's a pollution loss.

Mr. Thornberry: I have also heard the justification that if an insurance company denied the claim and you went to the courthouse, the courts wouldn't read the policy that way.

Mr. Harrel: Nobody would read it that way.

Mr. Thornberry: I guess my problem is why do we have language that appears—if there's an ambiguity, why don't we have it cleared up rather than in the policy.

Mr. Rinehimer: Would you like to volunteer to be on the next drafting committee?

Mr. Thornberry: That's what I thought you would say. What I have heard is that everyone has thought about it but nobody knows how to . . .

Mr. Harrel: That little crack that you want to talk about could turn into Boulder Dam. We have overdrafted the exclusion. We'll tell you, we'll tell anybody else, we overdrafted it. But anything else puts us back where we are today.

discovery proceedings.

- The personal injury section of the policy includes claims for pollution from third parties. In the 1985 version of the form, personal injury is defined to mean, in relevant part, "wrongful entry into . . . premises that the person occupies." (Definition 10. This was narrowed in the 1988 version.)

If my pollution travels into your land or water, this is a wrongful entry into premises that you occupy. Your claim against me would therefore be covered. By a plain reading of the policy, the pollution exclusion does not apply to personal injury; that section of the policy has its own exclusions and the pollution exclusion is not among them. This argument can be elaborated to cover entry of pollutants into groundwater owned by the state or public.

So far, perhaps most of the few courts that have considered this argument have held against it. These decisions should not discourage use of the argument. The 4th and 8th U.S. Circuit Courts of Appeals were among the first to decide the question whether "damages" in the coverage section of the CGL applied to the costs of remediation mandated by a government and held for the insurers. But the great weight of all subsequent cases is for policyholders, who were not discouraged by the early adverse decisions.

- Several courts have held that one or the other version of the new exclusions do not apply when the pollutant has infected the air inside a building.

To them, enclosed spaces are not the environment

at which the exclusion is aimed.

There are several other arguments for avoiding the pollution exclusions, including the pollution exclusion frequently endorsed to the property policy. But because the insurers could too easily foreclose use of them by small changes in language, I won't set them out here.

In sum, the pollution exclusions should be seen as obstacles but, in many circumstances, no more than that. In many circumstances you can cross over these obstacles into coverage.

The 10 arguments above all are aimed at obtaining indemnification. In many states, the case for obtaining a defense from the insurer is easier. In them, one need only show it is possible the claim falls under the policy, or more precisely, the insurer must show it is not possible for the claim to fall under the policy, which is no small burden. Until it can do so, it must defend you. Thus, you may often get at least a defense, even if in the end you do not receive indemnification. **BI**



Richard Levy is the principal of his law firm in Alexandria, Va. He is the co-author with his colleague, Leslie Foster, of "Underground Tank Leak Insurance...Understanding How Four of Your Policies May Cover You for Leaks."

Damages caused by professional services not covered under CGL policy

The Supreme Court of New Hampshire found that a general contractor for a construction project also provided services as an architect and engineer, thus excluding coverage under a comprehensive general liability insurance policy for damages arising out of professional services.

The MacMillin Co. Inc. constructed a facility for the Filtrine Manufacturing Co. in 1985-1986. After completion, the floor of the facility cracked, causing damage to equipment, necessitating repair of the floor and resulting in loss of use of the facility. Macmillin sued Filtrine seeking to

Legal Briefs

recover the balance remaining under the contract. Filtrine countersued alleging breach of contractual duty by MacMillin as architect, engineer and contractor.

During trial, this lawsuit was settled by MacMillin's agreeing to pay Filtrine \$250,000. Macmillin was covered under two Aetna Casualty & Surety Co. CGL and excess liability policies, which excluded coverage for damages arising out of the rendering of professional

services. Aetna had denied MacMillin's requests for defense and coverage of Filtrine's claims. MacMillin then brought this suit against Aetna.

The trial court ruled against Aetna.

On appeal, MacMillin argued that it was not an engineer or architectural firm and those services were incidental to its role as "general contractor." But, the contract specifically provided that MacMillin would serve as architect/engineer. MacMillin never entered into any subcontract for design and engineering services. Therefore, the express language of the CGL policy

excluded from coverage Filtrine's claim against MacMillin. The court held that the trial court erred.

MacMillin Co. vs. Aetna Casualty & Surety, Supreme Court of New Hampshire, Dec. 31, 1991, Rehearing denied Feb. 19, 1992 (BI/01/O.-\$10).

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a \$10 check payable to Mayo H. Stiegler to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

Fear of AIDS

Continued from page 2

cases as well as other types of phobia cases against their employers in other courts as well as under state workers compensation statutes.

Mr. Marchica's case is being brought under FELA, a 1908 law designed to provide railroad workers with a means by which they can bring negligence actions against their employers. Railroad employees typically are not covered under state workers comp laws.

In his lawsuit, Mr. Marchica alleges that he suffers from emotional distress. He maintains that since the injury occurred, he has lived with the fear that he is infected with the virus that leads to AIDS.

So far, numerous tests for the human immunodeficiency virus that causes AIDS have been negative, but his lawsuit points out that HIV can incubate for up to 10 years before manifesting itself.

The injury occurred when Mr. Marchica moved trash and broken bottles from an unkept area at the train station frequented by homeless people and drug users. According to his suit, when Mr. Marchica attempted to manually move the heap of trash from in front of the window he was assigned to repair, a used hypodermic needle pierced his protective glove and pricked his finger.

Mr. Marchica immediately placed the needle in a plastic bag and went to a local hospital where the wound was cleaned. At that time, he was advised to have an HIV test and hepatitis shot. He was also told to abstain from all sexual contact for at least six months.

Later that day, he went to the LIRR medical department where several staff doctors told him that he had nothing to worry about and that he should simply go home and wash his hand with warm, soapy water, the suit alleges. At that point, the LIRR medical staff took the needle from him, claiming it was property of the railroad, according to the suit.

The conflicting messages he received from the hospital and LIRR medical staff about whether he was prone to HIV infection—as well as the LIRR's confiscation of the needle which prevented him from testing it—is what has caused Mr. Marchica to live his life as though he is “on a death sentence,” according to his lawsuit.

“He doesn't have AIDS now, but for the next 10 years he'll have the fear of AIDS in the back of his mind,” said Michael Barasch, a partner with the New York law firm of Altier & Barasch, which represents Mr. Marchica.

Attorneys for the railroad could not be reached.

Other attorneys who specialize in labor and management safety disputes indicated that if the jury finds the railroad company was negligent in not providing Mr. Marchica with safe working conditions, his claim for fear of AIDS is probably justified.

“In most workplaces, AIDS phobia is irrational. But in this case, the questions are negligence and foreseeability of injury. If the jury finds that the railroad was negligent,” then his emotional distress claim should be compensated, said Jonathan Segal of Wolf, Black, Schorr & Solis-Cohen in Philadelphia, who works with employers on

safety matters, including AIDS protection.

Another employer attorney acknowledged that if the LIRR is found to have been negligent, then Mr. Marchica's emotional distress claim may be reasonable.

“In this case the fear may be reasonable, but where does it stop?” wondered Michael J. Lotito, a labor relations attorney in the San Francisco office of Jack-

son, Lewis, Schnitzler & Krupman. “This case is definitely worth watching because it could have a carry-over effect into state workers compensation systems, especially states that recognize stress claims.”

Mr. Barasch, the plaintiff's attorney, emphasized that as the first case brought under FELA, it has precedential value. “FELA was enacted exactly for this purpose: to give a worker the oppor-

tunity to sue in lieu of using the workers compensation system. With most cases, you don't have the privilege of suing over an unsafe workplace.”

The case is proceeding to court after U.S. District Judge Arthur Spatt last month denied the LIRR's motion for dismissal. The railroad had asked to court to dismiss the case on the ground that other courts have concluded that an injured party cannot re-

cover on a claim of fear of contracting a disease, including AIDS, where the plaintiff had not shown that he was exposed to the disease.

But Mr. Marchica's attorneys successfully argued that railroad workers may assert claims under FELA for wholly mental injuries if an injury occurs from unsafe working conditions and employer negligence, no matter how slight. **BI**

AMA cites factors behind health costs

By DEBORAH SHALOWITZ

Tobacco and alcohol use accounted for more than \$80 billion of the nation's \$546 billion health care bill in 1988, according to a report released last week by the American Medical Assn.

Other significant factors cited by the AMA are lifestyle factors like drug abuse, being overweight, violence, the failure to use life-saving technology like seat belts and smoke detectors, the failure to screen and treat life-threatening diseases, reckless recreation and promiscuous sexual practices.

Also, a health insurance system that shields consumers from realizing the full cost of the health care services they use exacerbates the problem of rising costs, the report states.

The statistic-filled 22-page report states that “much of the impetus behind the growth in health care expenditures can be traced to lifestyle factors and social problems.”

“We cannot overlook the responsibility of individuals to take care of themselves,” said Dr. Daniel Johnson Jr., speaker of the AMA's house of delegates. “Individual responsibility must be a significant part of any health system reform measure.”

Smoking-related medical services currently costs \$22 billion annually, according to the report. Other big factors are alcohol abuse—for which treatment cost \$58.2 billion in 1985—and drug abuse—which required another \$10.6 billion that year.

“We knew that those things contribute to the cost dilemma, but I really had not personally known that (lifestyle factors) contributed so highly to our health care bill,” commented Dr. Johnson, a radiologist who specializes in diagnostic imaging in Metairie, La.

In addition to taking responsibility for their health, individuals must be more aware of the true costs of the health care services they use, Dr. Johnson advised.

The problem is that “Americans are overin-

sured against health care expenditures,” the report states.

“Most employer-provided health insurance goes far beyond the bounds of what insurance is intended to do, which is to insure against risks that have a low likelihood of occurring but are very costly to pay for if they are realized,” the report contends.

“Consumers typically pay only a small percentage of the price of health services—after paying a modest deductible—which shields them from having to take into account the full cost of the services they consume, result-

‘We cannot overlook the responsibility of individuals to take care of themselves,’ says Dr. Daniel Johnson Jr., speaker of the AMA's house of delegates.

ing in much larger quantities being consumed of most health services than would be the case if they had to pay the full price.”

Dr. Johnson said the AMA supports a “benefit payment schedule” under which an insurer or self-insured employer would establish a set payment amount of a particular health care service. If the doctor's charge exceeded that amount, the individual—not the physician—would be responsible for the difference.

Such a financing arrangement would replace indemnity or prepaid health care plans.

This arrangement “puts the patient in the driver's seat,” said Dr. Johnson.

It would also be easy to understand, easy to administer and an employer or insurer's costs would be predictable and exposure would be limited, he said.

In its report, the AMA also addressed sev-

eral other issues.

For example, the report noted that general inflation was the leading cause behind the growth in personal health care expenditures during the 1980s.

The report stated that 47% of increase in health care costs during the decade can be attributed to inflation in general, while an additional 22% can be attributed to inflation in the cost of health care services.

Population growth accounted for 10% of the growth in health care expenditures, while the remaining 21% is attributed mainly to an increase in the amount of per-capita health care services provided and the use of more expensive services. This last category includes extra costs created by new medical technology and the drug development and approval process.

The AMA report also noted that according to a study issued by the U.S. General Accounting Office in May 1992, fraudulent or abusive health care services accounted for 10% of total U.S. health care spending. The GAO study said abuses included overcharging for services provided, charging for services not rendered, misrepresenting the services delivered, accepting kickbacks for referring patients, and rendering inappropriate or unnecessary services.

The GAO study also noted that although AIDS treatment accounts for only 1% or so of health care expenditures, it is expected to rise. For instance, \$10.3 billion was spent treating people with human immunodeficiency virus in 1992. By 1995, that figure is expected to be \$15.2 billion.

The report, “Factors Contributing to the Health Care Cost Problem” (Item No. NL 190992), is available from the American Medical Assn., P.O. Box 109050, Chicago, Ill. 60610; 800-621-8335. The cost is \$10 for AMA members and \$15 for non-members, plus \$4.95 shipping and handling.

Towers Perrin offers data analysis service

Products & Services

Towers Perrin has introduced a new health care data analysis service to help companies better manage their benefit costs.

MEDManager organizes raw health plan claims data and isolates specific information for analysis. The computerized service can accommodate health care data from indemnity plans, flexible benefit programs and managed care plans.

The service provides analysis in four main categories:

- Overall financial experience, including summary of utilization, covered expenses, claims and benefit payment data.
- Inpatient utilization information, such as which hospitals are providing care, lengths of stay and specific services and procedures provided.
- Outpatient utilization and expenses by type of service, such as surgery, mental health, substance abuse, prescription drugs, lab services and X-rays.
- High-benefit claimants, defined as claimants receiving more than \$20,000 in benefits during a set period. It also can analyze high-cost claims.

In addition to these services, MEDManager also can be used to set a baseline for measuring future claims experience, evaluate the im-

pact of cost-sharing features and monitor vendor performance, among other things.

The computer service can also help employers calculate benefit liabilities under new accounting rules.

MEDManager can project the cost of employers' liabilities under Financial Accounting Standard 112, which requires firms to account for post-employment benefits—like disability, workers comp and COBRA coverage—for non-retirees.

It also projects per capita claims costs and medical trend assumptions for FAS 106, which requires employers to account for retiree benefit liabilities.

Towers Perrin will provide the service from 28 U.S. benefit consulting offices. The cost will vary according to the information desired.

For more information on MEDManager, contact Steve Fein at 914-745-4114.

Real estate E&O

Transamerica Insurance Group is launching an errors and omissions coverage program for real estate agents and brokers.

Initially available in 20 states, the program offers E&O coverage on a claims-made basis, targeting real estate agents and brokers who specialize in residential real estate sales. Commercial real estate exposures can be written on a limited basis, as can property management and real estate auctioneering risks.

The policy covers the named real estate firm and its employees and independent contractors while providing professional services on behalf of the named insured.

Coverage is also provided for lock box liability, discrimination exposures and personal injury arising out of the performance of professional services.

Limits of up to \$1 million per claim/\$3 million aggregate are available, with higher limits possible under special circumstances.

The standard deductible of \$1,000 is applicable to damages only, except for discrimination and lock box coverages, where the deductible applies to both claims expenses and damages.

John Pearl & Associates Ltd., a Peoria, Ill.-based brokerage, administers the Transamerica program.

For more information contact Gary P. Pearl at 800-447-4982.

Rating changes faxed

Standard & Poor's Insurance Rating Services is now offering a fax service for its insurance company rating changes and press releases.

S&P Insurance Fax Alert will send subscribers its alerts of insurance rating changes, generally within 15 minutes of their release to the media. More than 200 bulletins are released annually by S&P.

Subscriptions to the fax service cost \$395 for 12 months. The service is available to subscribers outside the United States at separate prices. For more information, contact Priscilla Hart, 212-208-1592.

Books/videos

Copies of The 1992 Managed Care Yearbook are now available from American Business Publishing. The reference book contains a guide to managed care organizations, associations, statistics, costs and trends. Copies are \$149. To order, contact American Business Publishing, Brinley Professional Plaza, 3100 Highway 138, P.O. Box 1442, Wall Township, N.J., 07719-1442; 908-681-1133. **BI**

For the Record

A.M. Best reports '92 life/health results

Life and health insurers' earnings remained level in 1992, compared with a year earlier, at about \$13.2 billion, reports A.M. Best Co.

At the same time, the life/health industry was able to boost capital and surplus by 7.1% to \$113.3 billion from \$105.8 billion in 1991, according to a report by Best.

In its report, "Review of 1992/Preview of 1993," the rating company said the life/health industry's ability to maintain a "favorable level of earnings" was largely reflective of actions taken by many insurers to control expenses and improve business fundamentals.

However, Best said much of the life/health industry's operational

gains were offset by "lingering real estate problems, lower interest rates on new investments, increased taxes and weak economic conditions."

"Although the industry's surplus growth during 1992 was lower than the prior year's level of 13.6%, A.M. Best views 1992's increase as favorable due to the continued efforts that companies made to reduce their balance sheet and product risks," wrote Larry Mayewski, senior vp-life and health.

Best also reported that insolvencies fell to 32 in 1992, from an all-time high of 62 in 1991.

Jury awards \$16 million in insurance fraud case

SAN ANTONIO, Texas—A \$16 million jury award to a New York

Life Insurance Co. policyholder is "grossly disproportionate" to the reality of the case, the insurer claims.

The insurer has not decided whether to appeal the verdict that was awarded in February to a Texas woman the jury said was defrauded of \$100,000 by a New York Life agent.

The award includes \$15 million in punitive damages and \$1 million in actual damages. The award, subject to court approval, could grow to \$21 million if attorneys' fees of \$5 million are approved.

The jury found that Lamar Hernandez, a grandmother living in southern Texas, was bilked by an agent who altered a life insurance policy application by changing the limits to \$1 million from \$100,000 and forging Ms. Hernandez's signature.

Ms. Hernandez entrusted the agent with \$100,000 to purchase

the \$100,000 policy and other insurance products. The agent then used the money to pay premiums on the \$1 million policy, according to her attorney, Frank Herrera Jr. of San Antonio.

The jury found that New York Life disregarded corporate procedures in place to safeguard against such actions.

New York Life said "an award of \$16 million in a case where the amount under dispute was less than \$100,000 is grossly disproportionate to the reality of the case."

California's FAIR plan offers additional cover

LOS ANGELES—The California FAIR Plan, a property insurance pool that principally serves urban businesses and homeowners, is now offering optional replacement cost and business inter-

ruption coverages.

Previously the plan offered only standard fire insurance, which was based on the property's cash value and did not provide coverage for enhancements.

The expanded coverages come in response to complaints from small businesses in the wake of the 1992 Los Angeles riots.

At public hearings, many small businesses reported that they had not been able to obtain adequate coverage except through offshore surplus lines insurers, some of which were not paying riot-related claims.

To qualify for replacement cost coverage, the property must be insured to a minimum of 80% of the replacement value, and premiums will be adjusted accordingly.

The maximum building limits for commercial structures have been raised to \$3 million from \$1.5 million, though content limits remain at \$1.5 million. Total building and content limits also remain at \$1.5 million for residential structures.

Business interruption coverage, which carries a 12-month limit, must be purchased for a minimum of four months.

Though commercial policies represent only 15,000 of the plan's 113,000 policies, FAIR plan officials believe that the expanded coverages will draw more commercial policyholders.

AT&T plans to take \$7 billion charge

NEW YORK—American Telephone & Telegraph Co. expects to take an estimated \$7 billion aftertax charge in the first quarter of 1993 to account for its accumulated retiree health care liabilities under Financial Accounting Standard 106.

The charge will be partially offset by an estimated \$500 million in anticipated future tax benefits from implementing FAS 106. Companies are able to recognize that "deferred tax asset" under FAS 109.

AT&T, which has 141,000 retirees, was unable to estimate the charge it will take this year to meet the other FAS 106 requirement of accruing retiree health care obligations as an expense against earnings annually.

But a company actuary said the charge would have been larger if the company had not begun prefunding its retiree health benefits in 1991.

Louisiana rate hikes tied to fraud battles

BATON ROUGE, La.—Property/casualty insurers in Louisiana can forget about rate increases unless they can show how they plan to fight fraud, the state insurance commissioner says.

And, insurers are being asked to limit their profits in the state as a way to hold down rate hikes.

"When a company asks for a rate increase they're going to have to show us a fraud plan. If they can't... we're not even going to consider the rate increase," said Commissioner of Insurance Jim Brown.

Fraud is a significant factor in rising insurance rates in Louisiana, he said. "We now have a strong fraud law and hope to make inroads against perpetrators of fraud."

Insurers are also being asked to sacrifice profits to help hold down rates. "We are urging companies to set a goal of 25% margin above overhead, and I think those who are innovative can do even better than that," Mr. Brown said.

And during insurance company audits, regulators will begin discussing investment goals, the commissioner added. "Properly managing money is a solid way of keeping costs down for companies." **BI**

Editorial Index Service 1993

The Business Insurance Editorial Index Service is a valuable resource that directs you to all news reports and feature articles published by Business Insurance newsmagazine during the year.

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INTERNATIONAL

Mentor creditors approve payout plan

BERMUDA

HAMILTON, Bermuda—Creditors of insolvent Mentor Insurance Ltd. have given their near-unanimous support to a proposed scheme of arrangement, under which the bulk of the company's remaining \$175 million of assets are to be distributed by year-end 1994.

Mentor, a captive insurance subsidiary of Ocean Drilling & Exploration Co., was ordered into liquidation in June 1985.

Of 277 creditors represented at a special meeting in Bermuda last week, all but one voted in favor of the scheme. The 276 supporting creditors together have \$310 million in admitted claims pending against Mentor.

The scheme will be submitted for approval to the Bermuda Supreme Court on March 23. Afterward, creditors will have until June 30 to "finalize and file any and all remaining claims" with Mentor's joint liquidators.

The liquidators said in a statement that the adjudication of these claims is expected to take as long as 18 months, "following which substantially all the assets in the Mentor estate will be distributed to admitted scheme creditors."

The distribution is expected to be

worth approximately 15 cents on the dollar. Almost \$78 million was paid to Mentor's 700 U.K. and U.S. creditors in an initial dividend last year.

Liquidator Charles Kempe said the time taken to complete the claims adjudication process will depend on the extent to which new claims materialize from existing claimants.

"The vast majority of the claims will remain unchanged but there could be some adjustments on environmental impairment liability claims," he said. "Certainly, those with asbestosis and environmental liability claims on their books may want to examine their positions very carefully in light of the scheme's principal feature of imposing a full and final filing date."

However, he stressed that any creditor "aggrieved" by the adjudication can file an appeal with the Supreme Court.

But Mr. Kempe said he would be surprised to see many appeals, noting that of almost 900 claims originally received by the liquidators, only four are now under appeal.

The Mentor scheme represents the first "cutoff-type scheme of arrangement within a liquidation," he said. "It will require creditors to value any remaining unreported claims on an actuarial basis, which will then be adjudicated by the joint liquidators."

Catastrophe capacity

Insurance authorities in Britain and the United States should give "fresh thought" to ways to stimulate markets for property catastrophe reinsurance capacity, a reinsurer says.

Such initiatives are "critical to the commitment of both existing capacity and to the attraction of new capital and capacity," says Ian Heap, the president of Bermuda's newest property catastrophe reinsurer, Mid Ocean Reinsurance Co. Ltd.

The demands of the market and the increasing number and size of worldwide catastrophes have "produced a severe imbalance" between the supply of and the demand for catastrophe reinsurance, he said at a recent meeting of the Bermuda Insurance Institute.

This imbalance led to the formation of Mid Ocean, which started underwriting Nov. 16 after raising

more than \$350 million in equity capital (BI, Nov. 9, 1992).

"It is an imbalance that is greater in 1993 than it was in 1992, and there is no good reason to believe that the situation is getting better," he said. In a "free market" that is able to price products fairly, supply and demand should eventually come into balance. But in the property catastrophe market "other elements need to be changed... with new capital being a necessary ingredient."

But Mr. Heap said the "negatives of volatile annual earnings subject to taxation" and the "accounting prohibition on contingency reserves" act as "deterrents to the commitment of capital to a business which has been and will be inherently profitable over time."

Although an insurance product with a regular loss frequency and large premium volume can be priced on a yearly basis, a product like property catastrophe reinsurance must be priced over a longer period of time and requires a way to reserve for random and severe losses, he said.

"Accounting principles do not allow the creation of tax-free contingency reserves and, absent a reserve in a catastrophe-loss-free year, the apparent underwriting profit" is subject to taxation, Mr. Heap said. He said that worldwide, property

catastrophe capacity has fallen by about 20% over the last two years. London market capacity is about 40% lower, while retrocessional capacity is about half of what it was in 1990.

"At the present time, there is great difficulty in completing most U.S. catastrophe programs," he said. "It is difficult to assemble more than \$150 million in catastrophe protection for a major insurer."

"The situation on capacity may be a little better in the U.K., but it could be that price levels in that market may be slightly stronger. Certainly in Japan... there will be a shortfall in earthquake capacity at the upcoming renewal," he said.

The primary market in the United Kingdom has acted to raise prices, "but regulatory forces in the U.S. will deter similar actions, so in the U.S. there will be reductions in market shares by primary companies."

He predicted the future of the catastrophe reinsurance market will depend on whether primary insurers, particularly in the United States, raise rates and whether tax and accounting issues associated with catastrophe reserves are successfully addressed.

If they are, "there will be an inflow of capital and capacity will grow and ceding companies' needs... will be met," he said. **BI**

Shifting the cost of benefits

Employers pick up government's tab

By STACY SHAPIRO

LONDON—Employers worldwide are assuming more responsibility for employee benefits as governments try to cut the cost of social security and national health insurance programs, a report says.

"All over the world, employers are being asked to shoulder more of the burden of providing employee benefits," says London-based Noble

Lowndes Group Ltd. in a recent report on non-U.S. benefit trends, titled "Outlook '93."

"Whether it is the privatization of social security or the rising cost of medical treatment, the introduction of consumer protection laws or new accounting regulations, all the current issues lead inevitably to a greater burden on employers," the report says.

"Whether it is Belgium trying to bring the public debt within the target limits for European Monetary Union, or Argentina controlling public spending to heal an infla-

tionary economy, or Hungary trying to devise new affordable benefit systems, the net result is the same—a reduction in state benefit provision," the consultant says.

Several countries, including Italy and Sweden, have started to shift part of the burden of their "cradle-to-grave" social security systems to employers, according to Noble Lowndes.

And as employers take over responsibility for providing pension benefits, consumer protection legislation is in vogue to protect retirement benefits.

Consumer protection measures have gained favor in light of the alleged swindle of hundreds of millions of dollars from U.K. pension funds formerly controlled by the late media baron Robert Maxwell (BI, March 16, 1992).

"The reverberations of the Maxwell affair have also been felt within the European Community, with its Parliament attempting to introduce security measures within the draft pension funds directive," says Noble Lowndes.

The draft directive initially was only intended to remove barriers from cross-border pension fund investment and management.

The E.C. countries also must grapple with the equal treatment of men and women in pension plans after a 1990 European Court of Justice decision that ruled that pension plan provisions must not differentiate on gender (BI, May 28, 1990).

Three cases currently are before the European Court that all center on how to interpret the 1990 ruling (BI, Feb. 1).

Meanwhile, faced with escalating health care costs, "governments are putting a lid on their state systems by demanding higher contributions from individuals and their employers," says the consultant.

For example, 10 years ago the French national health insurance system covered about 80% of health care expenditures. Last year, the government covered less than 70%, says Noble Lowndes. **BI**

A look at benefit trends

LONDON—"Outlook '93," a publication on benefit trends from international benefit consultant Noble Lowndes Group Ltd., provides an overview of some recent legislative changes that affect employee benefits, particularly pension plans. The changes include:

- **Australia.** Employers are required to provide minimum retirement benefits under legislation that became effective July 1, 1992. For defined contribution plans, the minimum contribution for most employees is 5% of salary, rising to 9% by the year 2002.

- In October 1992, the government proposed measures to improve pension fund management. Proposals include: clearer definition of trustees' duties and responsibilities; limits on the amount of pension funds that can be invested in a company's own stock; and a possible levy on all funds to cover losses caused by fraud or theft.

- **Canada.** British Columbia last year became one of the last provinces to implement a federal Pensions Act that regulates employer pension plans.

- **Germany.** Reform of Germany's social security program took effect last year. Changes include an increase in employee contributions, provisions to equalize benefits for men and women, and an increase in benefits.

- **New Zealand.** A government committee is examining possible scenarios for cutting the expenses of the state pension system. The committee will make its final recommendations sometime this year.

- **South America.** Last year, a number of South American countries decided to totally or partially privatize their social security systems, including Argentina, Brazil, Colombia and Peru. This trend is based on Chile's implementation of a compulsory private sector retirement provision 10 years ago, Noble Lowndes says.

- **United Kingdom.** The United Kingdom is considering new pension fund legislation to better protect pension benefits. A pension law review committee is examining suggestions for legislation, which should be introduced into Parliament this year.

—By Stacy Shapiro

Lloyd's syndicates offer grim preview of 1990 results

By GAVIN SOUTER

LONDON—Litigation by Lloyd's of London members over losses is driving the market further into the red even though few cases have yet gone to trial, underwriters and agents say.

Reserves for claims against errors and omissions coverage, which will cover awards to or settlements with members, likely will total hundreds of millions of pounds in 1990, the year just closed under Lloyd's three-year accounting system.

Additions to E&O reserves come on top of already huge catastrophe losses that Lloyd's syndicates suffered in 1990.

These amounts could combine to help push Lloyd's overall losses for 1990 to more than 2 billion pounds (\$3.03 billion at appropriate exchange rate) for the second year in a row. That scenario is prompting a flurry of proposals to help the market shoulder the burden.

Although the Lloyd's overall results will not be published until June, grim statistics are starting to emerge as Lloyd's syndicates send estimates of their 1990 results to members' agents.

"Things seem to be getting worse by the day," said John Rew, chairman of the Society of Names.

"I wouldn't be surprised if we see a loss of around 2 billion pounds" for the entire market, said Anthony Cooper, chief executive of Wellington Underwriting Agencies Ltd.

Like 1989's record loss (BI, June 29, 1992), much of the losses for 1990 will be from syndicates with large exposures to catastrophe reinsurance, like those managed by Gooda Walker Ltd. and Feltrim Underwriting Agencies Ltd.

Gooda Walker last month reported that losses have deteriorated by 325 million pounds (\$472.9 million) through 1990 (BI, Feb. 8).

But an increasing proportion of the loss will be due to reserves made for potential E&O claims, according to Mr. Cooper. "E&O loss provisions could account for several hundred million pounds."

Currently, there are now 30 members' action groups either pursuing or considering litigation against members' agents, managing agents and underwriters.

In many cases, the litigation is not expected to reach the courts for at least two years. However, syndicates now have to make rough predictions on the size of their E&O claims exposure and make provisions for these losses.

These E&O losses could spiral throughout the market as many of the risks were insured, reinsured and retroceded within the Lloyd's market, said Edward Windsor-Clive, a director of members' agent R.F. Kershaw Ltd.

In addition, the uncertainty surrounding the level of E&O losses could cause the number of open underwriting years at Lloyd's to shoot up to more than

Continued on next page

Lloyd's syndicates

Continued from previous page
200 in 1990 from 162 in 1989, said Wellington's Mr. Cooper.

Some Wellington syndicates are expected to post heavy losses for 1990.

For example, syndicate 406 is expected to post 1990 losses of between 27% to 32% of its capacity of 100.7 million pounds (\$152.6 million). Syndicate 448 also expects 1990 losses of 27% to 32% of capacity, which was 120.4 million pounds (\$182.4 million).

While Wellington losses were expected by the market, other syndicates' losses surprised members' agents.

For example, syndicates managed by Sturge Holdings, Lloyd's largest managing agency, are expected to fare worse than had been anticipated.

The average loss for all 27 Sturge syndicates for 1990 will be between 10% and 12.5% of total capacity, which was about 1.1 billion pounds (\$1.67 billion) said Terry Hayday, chief executive of the insurance division of Sturge.

Sturge's two largest syndicates, 206 and 210, are likely to post losses above the agency's average.

"210 will probably make a loss in excess of 10% and 206 will probably make a loss in the order of 20% of capacity," Mr. Hayday said. "That is subject to them being able to close," he added.

Syndicate 210's 1990 capacity was 184.2 million pounds (\$279 million) and syndicate 206's was 175.8 million pounds (\$266.3 million).

Uncertainty over the size of the two syndicates' losses results from their exposure to environmental pollution claims, members' agent E&O claims and Lloyd's members' stop-loss claims, he said.

Even larger shocks to the market came from other managing agencies.

Syndicate 475, formerly managed by R.J. Bromley (Underwriting Agencies) P.L.C., is expected to lose more than 290% of capacity for its still-open 1989 account, members' agents say. Syndicate 475's 1989 capacity was 25.5 million pounds (\$37.1 million at appropriate exchange rates).

When the agency was taken over by Spratt & White Ltd. in December 1991, it was anticipated that syndicate 475 would make a profit in the 1990 underwriting year.

Roy Bromley, the syndicate's former underwriter, committed suicide in January when the size of losses at his former syndicate be-

came clear. Last December, Spratt & White said syndicate 475 would lose at least 200% of its capacity for 1989 and at least 50% of its 1990 capacity, which was 35.9 million pounds (\$54.3 million).

Any other estimates are "pure speculation," said John Gillespie managing director of Spratt & White.

Another big loss will be posted by syndicate 745, managed by KPH Underwriting Agencies Ltd.

KPH last October predicted the syndicate would lose between 90% and 140% of its 1990 capacity, which was 43.1 million pounds (\$65.4 million).

It is worth to members this week to advise them that the loss could be at "the 140% end," said Underwriter Andrew Elliot, who took over underwriting from David King last year.

Syndicate 745's estimate is "annoyingly typical" of many syndicates that last year gave a range of 1990 losses and are now saying that the loss will be nearer the top end of the range, said one members' agent.

The size of losses at syndicate 1035, managed by N.T. Evennett & Partners Ltd., also was unexpected.

The syndicate expects to incur losses on its still-open 1989 account of between or 150% to 200% of capacity, which was 21.9 million pounds (\$31.9 million at appropriate exchange rate).

Last year, when the 1989 account was due to close, the syndicate said it expected to lose about 100% of capacity.

Syndicate 1035 is expected to lose between or 20% to 25% of 1990 capacity, which was 24.1 million pounds (\$36.5 million).

Much of the 1989 loss is attributable to Hurricane Hugo, said Nigel Rogers, managing director of Octavian Syndicate Management Ltd., which acquired N.T. Evennett in late 1991.

Meanwhile, many at Lloyd's are discussing how to cope with the large losses the market is facing.

One suggestion is to leave all syndicates open for 1990 and effectively mutualize all prior-year losses.

However, many underwriters say this solution is unlikely to materialize.

"There are a lot of agencies and businesses in difficulties, but it does not seem very sensible to damage the businesses that are successful with such a broad-brush solution," said Colin Spence, managing director of Sedgwick Lloyd's Underwriting Agents Ltd.

Many profitable syndicates—for example, syndicates in Lloyd's motor market—do not need to leave 1990 open, he said.

To avoid hurting successful syndicates, Lloyd's could order all syndicates to keep their accounts open for 1990 and then allow successful syndicates to individually apply to close, suggested one Lloyd's underwriter.

Requiring all syndicates to remain open would alleviate some of the stigma that surrounds open syndicates, he said.

Another variation would be for syndicates with E&O exposures to leave open only that area of their account and close the rest, said Clive Pullen, assistant director at Wendover Underwriting Agency Ltd.

This way, syndicates would not need to make cash calls on members for E&O reserves until a clearer idea of the size of claims emerged, he said.

Other ideas floating around the market include making 1990 a four-year account and closing it at the same time 1991 is scheduled to close at year-end 1993.

Proponents of this idea say 1991 profits could ameliorate the 1990 losses. **BI**

Ingosstrakh exec moves on

By MARIA KIELMAS

LONDON—Mikhail Safronov, the former head of Russia's principal foreign insurer, Ingosstrakh and who left his post in October 1992 amid much acrimony, has emerged as chairman of the Moscow-based Westrosso Insurance Co.

Westrosso's technical personnel are mostly former Ingosstrakh employees, and the company's policyholders are also in large part former Ingosstrakh clients, Mr. Safronov said.

Westrosso is a joint stock company capitalized at 50 million rubles (\$87,000) with two principal shareholders: the Vladivostok-based Dalrosso Insurance Co., a major reinsurer in the Russian Far East, holds 70% of Westrosso, while Mr. Safronov personally holds the remaining 30%.

Mr. Safronov said the company's main lines of business will be aviation, construction, industrial fire, inland marine, marine hull, and some liability. He said it is too early to predict premium volumes for the new company, but he expects "a few million in hard currency" and in rubles.

East meets West

Russians confer with British about learning the ropes

By STACY SHAPIRO

LONDON—Russian insurance regulators are interested in staff training in the West and possible new legislation to govern brokers and reinsurers now that the country's first insurance law is in effect.

Last week, seven Russian insurance representatives spoke to British insurance officials about Russia's new insurance market. Meetings included those held with officials at the British Department of Trade and Industry, the Chartered Insurance Institute and the Assn. of British Insurers.

Among the discussion topics was training for Russian regulators and insurance officials, Yuri S. Bugaev, head of service for the Insurance Supervisory Federal Service of the Russian Fed-

eration, said through his translator Capitolina E. Turbina, deputy head of service for the agency.

An Insurance Supervisory Federal Service was set up in February last year, 10 months before the Russian government passed its first insurance law in December (BI, Feb. 1).

The law was enacted on Jan. 13.

Ms. Turbina was the first regulator to take instruction from the British DTI last year. The supervisory service now would like more of its 70 staff members to train with the DTI and British insurance organizations.

The agency also wants to develop its own training program in Russia.

"The Federal Service is quite a new organization, and there are no roots for insurance regulation in Russia," said Mr. Bugaev, who formerly was chairman of the Russian section of the Soviet Union's largest domestic insurer, Gosstrakh.

"So it's very important and very useful to be acquainted with the experience of foreign countries' regulation of their insurance markets."

The discussions also focused on the European regulation of brokers and reinsurers. Russia's new insurance law forbids brokers and intermediaries and does not address the ceding of reinsurance by domestic insurers, said Mr. Bugaev. The regulators now would like to find out more about how British regulators oversee the London broker and reinsurance market, he commented.

The Russian Federation's new insurance law is based on British insurance regulations, which focus on protecting insurer solvency rather than regulating policy wording and rates.

Private enterprise in Russia has been skeptical about any type of insurance regulation for fear of further state control, Russian insurance experts in London say.

But Westerners have urged such regulation to prevent insolvencies and boost policyholders' confidence.

The former Soviet Union had two state-controlled insurance companies, domestic insurer Gosstrakh and foreign insurer

Continued on next page

Westrosso's clients are mostly Russian companies with whom Mr. Safronov and his employees have had long business relationships during their years with Ingosstrakh. "We have taken a few clients (from Ingosstrakh); it's a competition," said Mr. Safronov.

He said his reasons for leaving Ingosstrakh are "a long story" related to general business policy at the company. He wanted Ingosstrakh to develop as a joint stock company firmly in the private sector. But both Ingosstrakh and the Russian Ministry of Finance, which is Ingosstrakh's major shareholder, opposed this strategy.

The new management at Ingosstrakh wants to keep the company as a state-controlled, centralized entity, said Mr. Safronov, explaining that this development reflects a growing opposition to free-market policies within Russia.

But Russia's shrinking trade volumes will in any case reduce Ingosstrakh's role, notes Mr. Safronov. In the past, Ingosstrakh wrote a lot of currency risk insurance, specifically in connection with imports and exports. "But now the level of trade has dropped dramatically and is only a fraction of five years ago, and foreign investment is very, very limited," he said.

This falling trade is one reason why Mr. Safronov expects Westrosso's clients will mostly be Russian companies.

Separately, a Dutch banker has proposed a government-sponsored political risk insurance scheme aimed at increasing trade and investment with Russia and the former Soviet republics, particularly in energy-related projects.

Herman Mulder, senior vp at the ABN AMRO Bank in Amsterdam, said serious consideration should be given to the development of a (European) Energy Private Investment Support program that would offer political risk insurance for private investors, including lenders, in energy projects.

The program, which should be provided by Western European governments, would include coverage of between 5 and 10 billion ECU (\$6 billion to \$12 billion) from 1993 to 1997 to get energy projects off the ground. **BI**

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INTERNATIONAL

Continued from previous page
Ingosstrakh.

The Russian Federation now has 824 licensed insurers and 300 more waiting to be licensed, said Mr. Bugaev. Premium volume for the licensed insurers at the end of last year totaled 43 billion rubles (\$74.8 million at current exchange rates).

But for the Russian insurance market to develop further, "we need more economic and political stability," Mr. Bugaev said.

Many of the insurance companies are "daughters of state enterprises" set up by the former Russian cooperatives, he said. They underwrite mainly life insurance, but they also write some types of property and accident coverages.

But Gosstrakh remains the largest and strongest insurer in Russia because "people don't trust" the newly formed insurers yet, said Mr. Bugaev. The new insurers also don't have the national distribution agency networks that Gosstrakh has, he added.

Under the new insurance law, foreign companies can only own up to 49% of a domestic insurance company. This includes Lloyd's of London, which is treated as a foreign insurer under the law and not as a unique institution, according to

Many of the Russian insurers are 'daughters of state enterprises,' says Yuri S. Bugaev.

Mr. Bugaev.

Lloyd's is "complicated to regulate," and discussions on how to treat this unique market continue, he said.

Foreign corporate policyholders with investments in Russia usually insure their property and other coverages in the Russian market. There is discussion, however, of providing a system of hard currency guarantees to foreign investors, which would be partially backed by the Russian government to provide political and credit risk coverage, said Mr. Bugaev.

In the meantime, a group of Western insurance groups led by Langton Syndicate Management Ltd., with the cooperation of the Russian insurance regulators, have set up the first major insurance conference in Russia.

More than 200 people are expected to attend the "First International Insurance Rendez-Vous," to be held April 27-29 at the Pine Forest Hotel outside Moscow.

Private meetings, such as at the Rendez-Vous de Septembre in Monte Carlo, as well as sessions will be held. Topics include insurance legislation in Russia, cooperation with international insurers, the population's changing attitude to insurance and insurer solvency.

The cost per person is \$2,000 and includes accommodation, meals, interpreters for social functions and local transport. For further information, contact the U.K. Co-Ordinating Office, First International Insurance Rendez-Vous, Moscow, Langton Syndicate Management Ltd., 21 Widegate St., London E1 7HP, England; 71-377-1188; fax: 71-247-7678. **BI**

But pension directive still far off

Nations seek EC pension guidance

By ALINE SULLIVAN

LONDON—European Community member governments are awaiting EC directives to guide reform of state pension systems as mounting budget deficits and the demands of rapidly aging populations threaten to overwhelm current retirement income programs.

But the process may be hindered by delays in EC pension legislation.

A draft EC pensions directive remains bogged down by debates over the regulation of state pensions and restrictions on investment, said Peter Morgan, an actuary at Bacon & Woodrow, the British arm of the Woodrow Milliman worldwide actuarial affiliation.

A potentially trickier problem is the harmonization of EC nation tax codes, which is widely regarded as a precondition for pension harmonization. An EC Commission proposal aimed at unifying tax regulation in EC countries remains a working paper and is unlikely to reach directive status in the foreseeable future, Mr. Morgan said.

"The ideal would be a pan-European (pension) system, but so many countries have such big problems with their own state pension arrangements that they can't face any more changes in revenue expectations," said Catherine Hope, a pension law specialist at London law firm Clyde & Co.

Most EC members operate a pay-as-you-go system in which pensions are funded by worker contributions. In almost all EC countries, when a large proportion of the population—the baby boom generation—approaches retirement, the number of people beginning employment and contributing to the system will be less than the number of people retiring.

As a result, the dependency ratio—the number of retired people in relation to the working population—will grow. The Organization for Economic Cooperation and Development expects the EC population to peak in 2000 at approximately

330 million, then drop by about 50 million in the next 50 years.

Current spending levels for retirement benefits, which have reached as high as 14% of annual gross national product in Italy and only slightly less in other EC countries, will be impossible to maintain.

EC governments are therefore encouraging citizens to invest in private retirement plans. In Britain and the Netherlands, this process has been going on for more than a decade. About 55% of British pensioners have a private retirement plan, and that number is growing.

In France, the government and opposition parties are asking whether there should be a state-backed insurance facility to back up company pensions, similar to Germany's pension guarantee fund and the Pension Benefit Guaranty Corp. in the United States. In Britain, no such insurance is available.

Jean Peyrelevade, chairman of the biggest French insurer, Union des Assurances de Paris, and an influential figure in France's ruling Socialist Party, has put forward another argument for company-sponsored pension plans. Private pension funds could be a new source of investment in French securities markets, diminishing the need for such widespread state control to fend off foreign predators.

This shift to the private sector has been welcomed by insurers. But the big problem remains taxation. Most EC countries are unwilling to allow tax deductions for insurance or pension-related investments by companies or workers, because ultimately the governments may not be able to levy taxes on benefits paid out.

The EC commissioner responsible for taxation, Christiane Scrivener, has indicated she has no immediate plans to harmonize personal taxation within the European Community. Multinational companies will continue to devote much time and effort to remuneration packages for years to come.

"The current draft directive doesn't deal with

taxation at all," Ms. Hope pointed out. "Until the EC cracks the taxation issue it won't get very far."

The most graphic example so far of the difficulties likely to be encountered came in 1991 in a case brought before the European Court of Justice in Luxembourg.

Hanns Martin Bachmann, a German national, had begun to pay premiums for health insurance and life insurance to a German insurer while residing in Germany. When he moved to Belgium to work, the Belgian tax authorities refused deduction of these premiums, although the premiums would have been tax-deductible to a Belgian citizen purchasing insurance from a Belgian insurer.

Mr. Bachmann took his case to the European Court of Justice, arguing that the Belgian tax authorities were discriminating against German insurance companies. The Belgian income tax code permits insurance premiums to be deducted against professional income, but only if paid to mutual insurance companies recognized in Belgium. No foreign companies have ever been recognized.

The Belgian tax authorities argued they should not be obliged to offer tax-deductible premiums if there was no certainty of them also being able to tax the benefits the policyholder stood to receive under the policy.

The European Court, while accepting that the Belgian tax legislation contravened the Treaty of Rome rules dealing with freedom of movement of workers and freedom to provide services, upheld the Belgian tax authorities' judgment.

The case highlighted a problem with the increasing mobility of individuals within the European market. When premiums can be paid in one country but benefits collected in another, the lack of a unified tax system can cause serious problems for employers relocating personnel.

Employees "will go to where they can get the best benefits," said Ms. Hope. "Companies will have to pay whatever it takes to get their executives to move." **BI**

Australian government panel to study workers comp

CANBERRA, Australia—Australian risk managers are welcoming a 15-month study of the nation's workers compensation system.

The study will be conducted by the Industry Commission, a government-funded independent advisory body. The panel has been asked by the government to investigate the differences among the state systems in terms of premiums, levies on employers and administrative costs. The study also will investigate the effect the differences have on businesses' competitiveness.

In certain states, employers must participate in a state-run workers comp program. Employers in those states pay a premium based on the size of their workforce and their type of business. In other states, employers can buy private workers comp insurance or self-insure. Some states also provide rebates for good loss records and impose levies for bad claims records.

Other topics on the panel's agenda are: whether the current system motivates employers to maintain safe workplaces; regulations that affect workers comp costs; the relationship between workers comp and other forms of insurance; and the interaction between workers comp and other government programs like social security and taxation.

The commission will conduct public hearings in April and May, and expects to release a draft report in mid-July. A final report must be submitted to the government by February 1994.

Although a new government may be elected during the March 13 federal elections, it would be unlikely to scrap a study in progress, according to risk managers.

—By Kate McIlwaine

GLOBAL BRIEFS

Horst Jannott dies

MUNICH, Germany—Horst Jannott, chairman of the management board and chief executive officer of Munich Reinsurance Co. A.G., the world's largest reinsurer, died of a heart attack Feb. 21.

Mr. Jannott, who was 65, planned to retire March 1 and head Munich Re's supervisory board of directors.

During his 23-year tenure as CEO of Munich Re, Mr. Jannott steered the company into its position as the world's largest reinsurer.

Mr. Jannott also helped guide German insurance regulation, serving on an advisory counsel to government regulators.

Hans-Juergen Schinzler, a member of Munich Re's management board, will succeed Mr. Jannott as chief executive.

—By Don Lewis Kirk

UNI Storebrand losses

OSLO, Norway—UNI Storebrand A/S will not comment on reports in the Norwegian financial press that the bankrupt insurer's 1992 losses will total approximately \$500 million, mostly due to the write-down of the company's 28% stake in Sweden's Skandia Group.

A UNI Storebrand spokesman said year-end results will be published March 8.

Two reports on UNI Storebrand's failed attempt to take over Skandia are expected to be released soon: one by a special commission examining the government's role in the debacle and another from the Oslo

Stock Exchange.

A January report by the UNI Storebrand's government-appointed administrator lambasted the insurer's former management for the failed takeover (BI, Feb. 1).

—By Maria Kielmas

Trade talk priority list

WASHINGTON—The American Insurance Assn. is recommending that seven countries be placed on a priority list for eliminating trade barriers under the current General Agreement of Tariffs and Trade talks.

"We would recommend that Japan, India, Thailand, Indonesia, Malaysia, Venezuela and Switzerland be placed at the top of the (United States trade representative's) priority list for the U.S. insurance industry—and pretty much in that order," Henry G. Parker III, chairman of the AIA's international committee, wrote in a Jan. 22 letter to Mickey Kantor, the U.S. representative to the trade talks.

"In addition, should China become a member of GATT later this year, we would clearly wish to elevate that country near the top of this priority list as well," he wrote.

The trade office had asked the AIA last November to review its list of insurance trade barriers being addressed in the GATT services trade negotiations.

—By Nancy P. Johnson

Italian market uproar

FLORENCE, Italy—Management shakeups at Italian multiline insurer Fondiaria S.p.A. prompted speculation that rival Assicurazioni Generali S.p.A. may be interested in making a

bid for some Fondiaria units.

Carlo Sama has been appointed Fondiaria chairman, succeeding Camillo de Benedetti, who died in January. Mr. Sama's appointment came after the resignation of Managing Director Alfonso Scarpa, who had been appointed to succeed Mr. de Benedetti in the day-to-day running of the company.

Fondiaria's new top executive is also the chairman of agro-industrial group Ferruzzi Finanziaria S.p.A.

Fondiaria is controlled jointly by Ferruzzi and Paleocapa S.p.A., a holding company that belonged to Mr. de Benedetti. Arrigo Bianchi di Lavagna will leave his post as managing director of Italy's biggest reinsurer group, Unione Italiana di Riassicurazione S.p.A., to run Fondiaria's day-to-day operations.

The management changes prompted speculation in the Milan stockmarket that Ferruzzi may be consolidating its hold over Fondiaria in order to sell off some of its subsidiaries and minority interests, said Marie Christine Keith, Italian equities analyst at London stockbroker County NatWest Securities.

Ms. Keith said there is speculation in the market that "Generali may be interested in buying some of Fondiaria's life insurance operations."

Generali declined to comment on the stock market rumors.

Possible candidates for the selling block include Fondiaria's 20% stake in German insurer Aachener & Munchener Beteiligungs A.G. The Italian insurer paid about \$360 million last year to buy a 14.2% stake in AMB (BI, April 13, 1992).

According to analysts, Fondiaria has said it has no intent to sell off any subsidiaries or other interests.

—By Aline Sullivan

Redlining

Continued from page 3

"It is very clear there is a great deal of interest" in allegations of redlining, both in insurance and in banking, Mr. Farmer said.

It is not clear, he added, whether Congress will perceive redlining as more important than solvency regulation and McCarran-Ferguson reform, the issues that dominated insurance debates during the last Congress.

However, "I think Congress is off to a very slow start on solvency and it appears the members don't have any real sense of urgency," said Marc Rosenberg, vp-federal affairs for the Insurance Information Institute in Washington.

"And I can't imagine that Congress will do anything on McCarran-Ferguson until after the Supreme Court has rendered its decision in the (insurance industry antitrust case). That leaves redlining," he said.

"Redlining comes up so quickly (because) it fits in with other congressional agendas like fixing the problems of the inner cities without spending federal money."

But Peter A. Lefkin, vp-governance and industry affairs for Fireman's Fund Insurance Cos. in Washington, said the redlining issue could actually spur debate on McCarran reform. He said it

could give House Judiciary Chairman Jack Brooks, D-Texas, "a hook to hang McCarran reform on" and provide an impetus for movement on H.R. 9, Rep. Brooks' bill that insurers fear would gut the law.

Renewed congressional interest in redlining follows release of a report by the Chicago-based Assn. of Community Organization for Reform Now, or ACORN, alleging that redlining persists in urban areas.

Insurers contend that the activist group used a skimpy sample designed to bolster its positions.

But Consumer Credit and Insurance Subcommittee Chairman Joseph P. Kennedy II, D-Mass., cited the ACORN report in his opening remarks as proof that redlining exists, and called the practice part of a "system of economic apartheid."

He also warned that the hearing would simply be the first of a series by his subcommittee into redlining and hinted at other actions he would like to take.

"I for one believe that we need to see more data from insurance companies on where they do and do not write policies, much like the Home Mortgage Disclosure Act requires banks to produce data on mortgage loans. Such data will shed some much-needed light on industry practices, and put to the test its con-

tention that discrimination does not exist.

"We should also consider giving consumers the right to know why they have been turned down for insurance, much like the right they now have to know why they have been turned down for credit," he said. "Such a requirement would strongly discourage insurers from using underwriting standards unrelated to risk."

'I for one believe that we need to see more data from insurance companies on where they do and do not write policies, much like the Home Mortgage Disclosure Act requires banks to produce data on mortgage loans,' says Sen. Joseph P. Kennedy II.

Rep. Kennedy's recommendations were mild compared with some offered by witnesses at the hearing.

The Rev. Charles Cummings Jr., treasurer of the Washington chapter of ACORN, called on the federal government to take 10 steps to end redlining.

These included: requiring insurers to disclose where they have written or denied homeowners policies; what underwriting criteria they use; where they locate agents; why they have canceled coverage or raised rates; and where they invest pol-

icyholder premiums.

The Rev. Cummings also called on the federal government to subject insurers to "community support requirements" under which they would be reviewed on, among other things, their reinvestment of premiums in the communities from which they collect them.

"Just as banks are subject to disclosure and reinvestment re-

sumably associated with risk."

Mr. Squires charged that many agents deliberately steer minority customers into FAIR plans—which are residual markets for difficult-to-obtain property coverage backed by the federal government—rather than sell traditional policies. Insurers also avoid assigning agents to inner-city areas, he said.

To remedy the situation, Mr. Squires advocated requiring property insurers to disclose for each application the race, gender and income of the applicant, the age, location and value of the property and whether the application was approved or denied. He also called for requiring insurers to disclose their underwriting criteria.

Mr. Squires condemned state regulation as being "very weak on consumer issues." He said that a possible solution would be to federally license insurers, with guaranteed service to low-income areas as a condition for licensing.

California Insurance Commissioner John Garamendi supports a greater federal role in controlling unlicensed offshore insurers and in combatting insurance crime, but he backs away from getting Washington too deeply involved in the redlining issue. Rates and market conduct should be supervised by the states, he told the subcommittee. **BI**

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Broker results

Continued from page 1

pointed to rate increases in primary property insurance and some types of reinsurance.

In addition, brokers should see a stronger economy in 1993, which will "take pressure off of revenue growth," said Vanessa Wilson, an equity researcher with The First Boston Corp. in New York.

Analysts agree, though, that brokers will not report significantly stronger earnings until 1994.

Changes in the insurance market and overall economy will not immediately translate into increased commissions—and then higher profits—for brokers, Mr. Smith said.

Brokers should "start seeing more meaningful revenue growth and margins" in 1994, Ms. Wilson concurs.

Brokers continued to hold down expenses in 1992, enabling half of the publicly held intermediaries to report higher profits despite continued declines in some insurance rates.

The best bottom-line performer during 1992 was Hilb, Rogal & Hamilton Co., which reported nearly a 68% increase in net income. Arthur J. Gallagher & Co. Inc. and Acordia Inc. also reported increases in their bottom lines of 24.4% and 8.7%, respectively.

Marsh & McLennan Cos. Inc. reported that profits fell by 13.7% last year, while Alexander & Alexander Services Inc. and Rollins Hudig Hall reported year-end losses. But non-brokerage-related charges were responsible for the woes at all three brokers, and each reported increases in operating income.

The seventh publicly held U.S. broker, Poe & Associates Inc., had not released its 1992 results as of last week.

The brokers managed to cope in the "difficult environment" of 1992 by cutting expenses, Ms. Wilson noted. Last year was a "year of trying to get business to operate as efficiently as possible, and lots of brokers have been very successful" in decreasing head count and operating expenses, she said.

But even with strict cost-control programs the order of the day, brokers could not overcome the double-whammy of soft insurance rates and declining investment income.

New York-based A&A was hurt by the soft market and the company "lost significant revenue to low interest rates," said Corporate Secretary Frank R. Wiczynski.

M&M also was "hit heavily by short-term interest rates," said J. Michael Bischoff, vp-corporate development for the New York-based broker.

Even though brokers see signs of improvement, they remain cautious and are sticking with tight cost controls.

In 1993, M&M will "continue in insurance operations as if change will not occur," Mr. Bischoff said. And while the broker is "somewhat more optimistic in '93," it plans to "continue to keep strains" on expenses.

A&A will "continue to ride herd" with its cost-containment programs, Mr. Wiczynski said. "We're not budgeting for any major turn in the marketplace." It will be "another tough year to hammer out increases in operating income," he said.

"We're not planning on anything but a mirror of '92," stressed Mr. Cloherty.

Individual results for the publicly held brokers follow:

Marsh & McLennan

Gross revenues for the world's largest broker rose 5.7% to \$2.94 billion last year from \$2.78 billion in 1991. Net income for the year how-

ever, dropped 13.7% to \$263.7 million from \$305.5 million in 1991.

The decline in profits can be attributed to a \$40.1 million aftertax charge M&M took to recognize retiree health care liabilities under Financial Accounting Standard 106, Mr. Bischoff said.

In addition, 1991 profits were boosted by the \$43 million collected by M&M when it sold its 30% share of Dutch broker Hudig-Langeveldt Group bv to Aon Corp., parent of the current Rollins Hudig Hall.

Pretax operating income, which does not include the accounting charge or the profit from the Hudig sale, increased 8.6% to \$541 million in 1992 from \$498.1 million the previous year.

While M&M's revenues increased nearly 6% for the year, insurance services revenues—including brokerage commissions—rose only 3.9% to \$1.63 billion from \$1.57 billion in 1991. And, consulting revenues—including revenues from benefit consultant William M. Mercer Inc.—increased only 1.6% to \$908.2 million from \$894 million in 1991.

The key contributor to M&M's increased revenues was The Putnam Cos., M&M's Boston-based investment management subsidiary. Investment management revenues for 1992 totaled \$396 million, a 26% increase from \$314.2 million in 1991.

Despite a difficult operating environment, "investment management operations had a very remarkable year in '92," Mr. Bischoff said.

M&M remained committed to cost control, he noted, as expenses for the year increased only 5% to \$2.4 billion from \$2.28 billion in 1991.

Alexander & Alexander

Although A&A's 1992 results may look dismal at first glance, Mr. Wiczynski contends that "trying to gauge how we did from '91 to '92" is comparing "an apple to an orange."

Gross revenues dropped 1.4% to \$1.35 billion in 1992 from \$1.37 billion in 1991. A&A reported a net loss of \$90.1 million for 1992, nearly eight times larger than the \$12.6 million net loss it reported the previous year.

But the 1992 loss was created by a \$157.5 million special charge A&A took in the fourth quarter to cover asbestos and pollution liabilities incurred by Sphere Drake Insurance Co. While A&A sold Sphere Drake in 1987, it guaranteed the insurer's loss reserves and reinsurance recoverables. The \$157.5 million is the company's "best estimate of future liabilities" incurred by Sphere Drake, Mr. Wiczynski said.

The charge also results from an increase in provisions for litigation and other exposures related to sold or discontinued businesses.

Excluding the special charge, the effect of exchange rates and operations sold in 1992, A&A's operating income increased more than 14% over 1991 levels, Mr. Wiczynski said.

"We had a reasonably good year from an operating standpoint," he said, noting the special charge was not related to A&A's core business.

And the broker was able to hold operating expenses to \$1.26 billion, a mere 2.1% rise from 1991, excluding the extraordinary factors, he said.

Rollins Hudig Hall

Chicago-based RHH reported the biggest increase in gross revenues for the year, an acquisition-fueled 81.7% to \$726.7 million from \$399.9 million in 1991. However, RHH reported a \$1.7 million pretax loss for its insurance brokerage and consulting services, compared with a \$33.7 million profit last year.

Revenue figures for 1992 reflect a full year of results from Hudig-Langeveldt, compared with only about

one month in 1991, plus nearly two months of revenues from Frank B. Hall & Co. Inc., which was acquired in early November, said Patrick G. Ryan, chairman and CEO of Aon, RHH's parent company.

The combination of the former Rollins Burdick Hunter Co., Hudig-Langeveldt and Frank B. Hall & Co. "has gone extremely well," Mr. Ryan said.

Despite the consolidation costs, "expenses were well-controlled" for the year, he added.

Domestic retail brokerage revenues increased 19.5% in 1992 to \$255.6 million from \$213.9 million in 1991.

RHH also saw increases in revenues from its sponsored programs, reinsurance services, and benefit and consulting services units.

International brokerage revenues alone, however, increased 500% for the year, to \$231.5 million in 1992 from \$19.4 million in 1991 because of the acquisition of Hudig-Langeveldt.

RHH's 1992 pretax loss can be attributed to a \$68.4 million special charge the broker took in the fourth quarter, reflecting consolidation costs, severance pay and an early retirement plan, Mr. Ryan said.

Arthur J. Gallagher

Gallagher's gross revenues jumped 10.4% to \$272.7 million during 1992 from a restated \$247 million in 1991.

Net income for the broker jumped even more, soaring 24.4% to \$23.5 million from a restated \$18.9 million in 1991.

Expenses for the Itasca, Ill.—based broker increased 7.3% for the year to \$236.6 million from \$220.5 million in 1992.

The effect of the soft market was demonstrated in single-digit commission revenue growth. Commissions rose only 4.1% to \$155.4 million from \$149.3 million in 1992.

Overall, "we are extremely pleased that we closed the year in fine fashion," Mr. Cloherty said.

Gallagher increased its profits in the wake of the soft market, low interest rates and the dismal economy because "everyone concentrated on new business development," he said. "We concentrated on spending money on what gets results."

Revenues generated from fees showed the emphasis on new business, increasing 20.3% for the year to \$105.5 million from \$87.7 in 1991.

In addition, Gallagher's business retention programs and expense-control programs "both paid off in 1992," Mr. Cloherty said.

Acordia

Gross revenues for the Indianapolis-based broker rose 12.7% in 1992 to \$207.2 million from \$183.9 million in 1991. Net income jumped 8.7% to \$20.2 million from \$18.6 million in 1991.

Unlike most other brokers, Acordia's expenses grew quicker than revenues, jumping 14% to \$172 mil-

1992 broker results

in millions

Broker	Gross revenues	% change	Net income	% change
Marsh & McLennan	\$2,937,000	5.7%	\$263,700	-13.7%
Alexander & Alexander	1,350,200	-1.4	-90,100	NM
Rollins Hudig Hall	726,700	81.7	-1,700 ¹	NM
Arthur J. Gallagher	272,725	10.4	23,470	24.4
Acordia	207,219	12.7	20,238	8.7
Hilb, Rogal & Hamilton	125,856	-1.2	8,399	67.9

NM - Not meaningful ¹ Pretax income
Source: Company reports

GRAPHIC BY JOHN J. BOHORQUEZ

lion last year from \$151 million in 1991.

Contributing to the increase in total expenses for 1992 was a 24.4% hike in employee compensation and benefits. However, that increase includes a \$2.3 million pretax charge resulting from the accelerated vesting of stock awards connected with Acordia's initial public offering last June (BI, June 29, 1992).

Acordia's 1992 success can be attributed to "improved operating efficiency," said Tom Zahneman, vp and treasurer. Acordia, which was formed through the combination of freestanding business units, incurred higher costs from 1989

through 1991 when the units were consolidated, he said. "We are maturing now."

Acordia's 1992 results included a full year of operations from Robinson-Conner Inc., which Acordia acquired in March 1991. Robinson-Conner's operations accounted for a 5% increase in both revenues and expenses last year.

Hilb, Rogal & Hamilton

Gross revenues for the Glen Allen, Va.-based broker fell 1.2% last year to \$125.9 million from \$127.4 million in 1991. Net income, though, jumped 67.9% to \$8.4 million from \$5 million in 1991.

The increased profit can be attributed to "good solid expense control," said Executive Vp Jay Adams. The slight decline in revenue was caused by the "continuing existence of the soft insurance market and the economy."

Operating expenses declined 2.9% to \$32 million from \$32.9 million last year. And compensation and employee benefit expenses fell 5.4% in 1992 to \$72.2 million from \$76.3 million in 1991.

"We were very careful in hiring quality instead of quantity," he said.

HRH recently announced a public offering of 1.4 million shares of company stock in an attempt to raise more than \$20 million. The funds will be used to finance future acquisitions, Mr. Adams said. **BI**

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High praise for antitrust litigation lawyers

By JUDY GREENWALD

WASHINGTON—The Supreme Court experience of the attorneys on both sides of the insurance antitrust litigation ranges widely. Two of the four are rookies, while one could wind up with more appearances before the court than any other lawyer this century.

But each of the four is highly respected and prominent in his or her field. And each is de-

scribed by colleagues and friends as having both a sharp intelligence and a deep knowledge of the law.

Here are profiles of the four attorneys:

Steven M. Shapiro

Mr. Shapiro, 47, made his 20th appearance before the Supreme Court when he represented the domestic defendants last week. That puts him squarely in the middle among the attorneys in

Legal lineup's experience runs the gamut

terms of Supreme Court experience.

"I try to be straightforward with the court," said Mr. Shapiro, who heads Chicago-based Mayer, Brown & Platt's appellate and Supreme Court litigation

practice and has written a standard treatise on Supreme Court litigation.

His goal is to simplify matters. Cases like the antitrust litigation are complex, and the justices will not have had a great deal of time to study the briefs, so Mr. Shapiro said he focuses on the essential issues.

It is also "most important" to be able to answer the justices' questions and to help the court, he said. "It's not an oration," he

said. Years ago, attorneys argued their cases for hours and even days. Now, he said, it is "very much a dialogue," and an attorney must be responsive to questions.

"The Supreme Court expects the cool light of rationality to be diffused over the case," not "overwrought emotion," said Mr. Shapiro. The justices are looking for a lawyerly approach, and "not some jury argument," he said.

Colleagues praise Mr. Shapiro's courtroom manner. "He's to the point, he's lucid, he's logical, he's emphatic where he has to be emphatic, he's persuasive, but he's not flamboyant," said Kenneth Geller, who is in Mayer, Brown's Washington office and has known him since 1978.

He also "deals extremely well with questions," said Mark Levy, who is with Mayer, Brown in Chicago. When asked a question, he answers it, incorporates it into the broader outlines of the argument, then returns to the major points of the argument.

"His arguments are thoroughly prepared. He speaks well and softly, and you're just on the edge of your chair listening to him," said

John Raleigh, who worked with Mr. Shapiro when Mr. Raleigh headed the appeal and research section of the General Motors Corp. legal department.



Mr. Shapiro

Mr. Raleigh added, "I think the reason he speaks so well is he thinks so well."

The praise does not stop at the courthouse steps. "He's fun, he's down-to earth, he's always pleasant," said Mr. Geller, adding he has never seen him lose his temper.

"Everybody likes him and I think what's characteristic of some of the best lawyers is they're not only knowledgeable of the law and speak well, but people like them intuitively," said Mr. Raleigh.

Mr. Shapiro joined Mayer, Brown in 1972, shortly after his graduation from Yale Law School. Between 1978 and 1983 he took a leave of absence from the firm to work in the U.S. solicitor general's office.

Mr. Shapiro is married and has two children, aged 6 and 4. When he has time, he reads English literature. "I do enjoy reading, and I make time for that," he said.

Molly S. Boast

"I'm excited and terrified at the same time," said Ms. Boast, 44, on the eve of her first appearance before the Supreme Court.

Ms. Boast, who is with LeBoeuf Lamb in New York and represented the foreign defendants, said she was happy to realize the U.S. Supreme Court courtroom is actually more intimate than most lower appellate courts.

"In a way, that makes it less intimidating," she said, because she will be physically closer to the judges.

Having read the opinions of the justices also helps, she said. "Somehow it is less foreign, even though I consider the responsibility truly awesome."

Continued on next page

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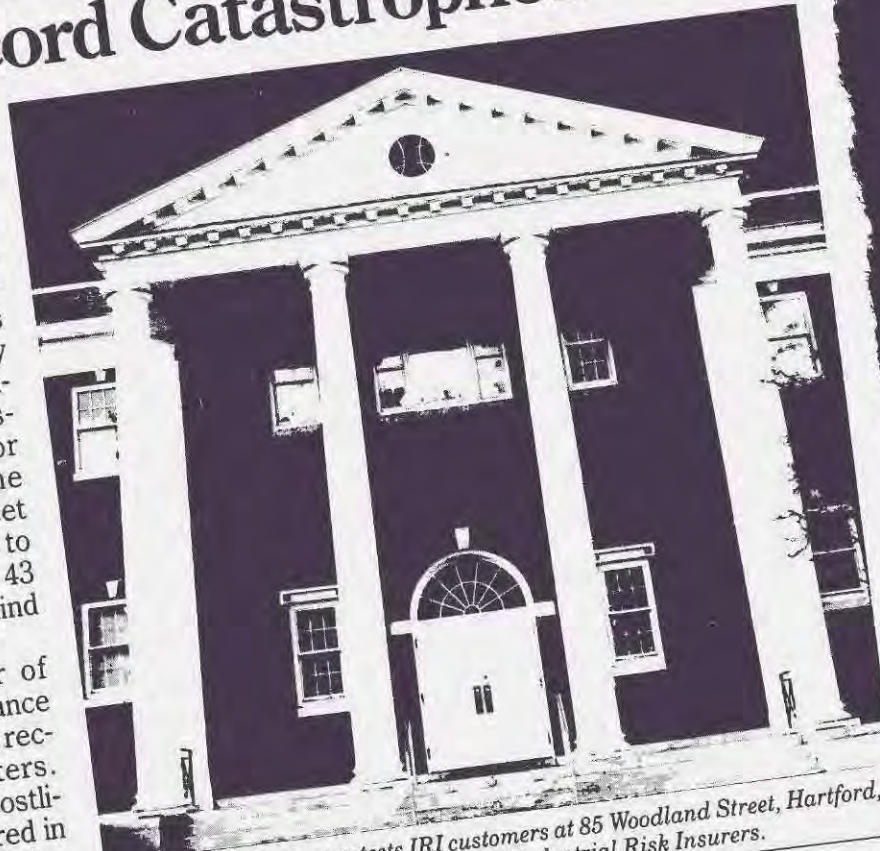
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Continued from previous page

"She's one of the best attorneys with whom I've ever worked," said Frederick Lacey, a LeBoeuf Lamb partner. "She's creative in her approach to problems and innovative in her thinking."

"I love working with her," said LeBoeuf Lamb associate Margaret Keane. She added that Ms. Boast, one of the 15 women among the firm's 163 partners, has in many ways been a model to associates, particularly women.



Ms. Boast

Ms. Boast, who attended Columbia Law School, and also has a master's degree in journalism from Columbia, lives in Brooklyn with her husband and 5-year-old daughter. While virtually all her spare time is spent with her daughter, she also enjoys bicycling, cross-country skiing, ice skating, putting in the garden, reading and cooking.

Laurel A. Price

During his 20 years in the New Jersey Attorney General's office, Mr. Price, 48, has specialized in complex, multi-district federal litigation.

Among his successes was representing the state attorneys general in the antitrust action before the 9th U.S. Circuit Court of Appeals.

Until last Tuesday, he had never appeared before the U.S. Supreme Court. "Frankly, it's one of the things I've wanted to do almost since before I became a lawyer. It's the best court in town," said Mr. Price, who describes his style as "somewhere between Perry Mason and an Armenian rug salesman."

"The litigation world is equal parts, almost packaging sales and legal skills," he explained. "It's trying to see the case as a whole and not get lost in the detail."

He also jokes he is somewhat uncomfortable with the recent media attention he has received because it interferes with his image as a "country lawyer."

No stranger to antitrust work, Mr. Price chairs the prestigious Multistate Antitrust Task force of the National Assn. of Attorneys General.

"He's extremely well-respected among his peers as an antitrust lawyer," said Robert Langer, an assistant attorney general for Connecticut, who has worked with Mr. Price for 20 years.

Mr. Langer praises his colleague's analytical skills and depth of knowledge, but also his sense of humor. "A healthy cynicism and a good sense of humor go a long way," he said, and in 20 years of dealing with both private attorneys and the federal government, Mr. Price has developed both.

"He really has just enormous energy," Mr. Langer said, adding that Mr. Price travels nowhere without a computer and printer.

Mr. Price is also ready to help others, said Ellen Cooper, assistant attorney general for Maryland. Ms. Cooper said when she

first started out in the Maryland attorney general's office seven years ago without any previous antitrust experience, "he was one of the people who was available to give advice and help to a lawyer getting started."

Ms. Cooper noted Mr. Price could have left the attorney general's office long ago for private antitrust work at a much higher salary. But, "I think he just enjoys what he does," she said. "There's a lot of satisfaction to being a government lawyer."

Mr. Price, a Columbia Law School graduate, has been married for 23 years and has a 14-

year-old daughter. His hobbies—when he has the time—include building model airplanes and needlepoint.

Lawrence G. Wallace

In stark contrast to Mr. Price, who made his first Supreme Court appearance last week, Senior Deputy Solicitor General Lawrence Wallace made his 120th.

At the pace he is going, Mr. Wallace will one day have made more appearances than any other attorney—in or out of government service—this century, said one of his former bosses, Rex Lee, who was solicitor general from 1981 to 1985.

Antitrust arguments

Continued from page 1

In March 1988, state attorneys general alleged that the insurance industry defendants—which included major U.S. insurers and reinsurers, the Insurance Services Office Inc. and the Reinsurance Assn. of America, several London underwriters and assorted other defendants—engaged in a boycott to force the approval of ISO's commercial general liability policy form (BI, March 28, 1988).

The suits allege the defendants conspired to manipulate the U.S. commercial liability insurance market. ISO, the suits state, was forced to rewrite its new commercial general liability policy form to exclude coverage for pollution and to include a retroactive date in the claims-made version of the form.

The defendants also allegedly conspired to eliminate occurrence-based CGL coverage and to include defense costs within policy limits.

Specifically, the suits charge that primary insurance company defendants—Allstate Insurance Co., Aetna Casualty & Surety Co., Hartford Fire Insurance Co. and CIGNA Corp.—wanted to eliminate coverage for long-tail and pollution liability risks, but law that unilaterally discontinuing these coverages could have cost them significant market share.

To force all insurers to abandon these products, the defendants entered into agreements with a "reinsurance cartel" to enforce the desired changes, the suits allege. The defendants' actions effectively precluded U.S. companies from selling some types of long-tail liability insurance and pollution insurance.

While the Supreme Court agreed to consider three issues connected with the case when it announced in October it would review it (BI, Oct. 12, 1991), one issue attracted most of the court's interest on Tuesday: whether the alleged agreements among primary insurers and reinsurers to compel competitors to stop selling certain products constituted a boycott outside the antitrust exemption provided under McCarran-Ferguson.

The justices appeared less interested in whether normally exempt domestic insurers forfeit their antitrust exemption under McCarran-Ferguson by alleging conspiring with foreign reinsurers that are not subject to state regulation in the United States.

The third issue of comity, which is a mutual respect for foreign law, drew few questions from the justices.

The suit would only be dismissed if the Supreme Court rules in favor of the defendants on both of the antitrust issues. A ruling in their favor on the comity issue likely would lead only to the dismissal of some foreign defendants.

If the Supreme Court rules against the defendants on either of the antitrust issues, the case could either be returned to the 9th Circuit for further proceedings or remanded to the U.S. District Court for pre-trial discovery.

Mr. Briggs, the Prudential Re attorney, said: "If I were betting," he would wager that the court will rule in the defendants' favor on the issue of forfeiture, and with the states on the comity question. "I'm reluctant to place a bet on the boycott question."

However, "I think both sides will get at least three votes on the boycott question," said Mr. Briggs, who did not specify which justices would take which side.

Any assessment of how the court will rule was clouded by the fact that many of the justices did not participate in the questioning during oral arguments. The most questions by far were asked by Justice Antonin Scalia, followed by Justice Anthony M. Kennedy and Chief Justice William H. Rehnquist.

The remaining six justices remained largely silent. Some observers were particularly puzzled that Justice John Paul Stevens, a former antitrust

attorney, did not ask more than a few questions.

However, some noted that the antitrust arguments were heard at the end of a long day, and the justices may simply have been tired.

Furthermore, it is difficult to predict even in the cases of the justices who did ask questions which way they are likely to ultimately vote. Sometimes a justice will closely question an attorney whose position the justice actually agrees with to probe possible weaknesses in the argument. And, sometimes justices will question an attorney to make a point to fellow justices.

Some attorneys pointed out that the complex nature of the insurance business may have disrupted the arguments.

At the beginning of the hearing, "there seemed to be some confusion" about the nature of the transactions between insurers and reinsurers, though this was eventually clarified, said Michael M. Uhlmann, an attorney with Pepper, Hamilton & Sheetz in Washington, which represents Hartford in the litigation. "This is not an easy case to comprehend for someone who hasn't lived with it a long time."

The court rarely hears insurance antitrust cases, some observers pointed out. And the attorneys were given an hour-and-a-half for oral arguments instead of the usual hour, which also is rare.

Representing U.S. insurance industry defendants was Steven M. Shapiro, of Chicago-based Mayer, Brown & Platt, while Molly Boast, an attorney with LeBoeuf, Lamb, Leiby & MacRae in New York, represented foreign defendants (see story, page 28).

Laurel A. Price, deputy New Jersey attorney general, represented the 19 states that brought the antitrust action, while Senior Deputy U.S. Solicitor General Lawrence G. Wallace represented the federal government, which supports the plaintiffs.

In general, the justices during their questioning focused on highly technical legal issues, including what constitutes a boycott.

In his presentation, which was the one most frequently interrupted by the justices, Mr. Shapiro stressed the defendants had not engaged in a boycott, but had simply agreed on acceptable forms of coverage.

Congress recognized in enacting McCarran-Ferguson that standardized policy forms were critical to the insurance business and thus must be agreed upon by insurers and reinsurers, he said.

Mr. Shapiro used his last minute of time to draw a distinction between this case and a 1978 insurance antitrust case, *St. Paul Fire & Marine Insurance Co. vs. Barry*, in which the Supreme Court had concluded there was a boycott. In that dispute, he argued, a single group of doctors had been singled out, while in the current case, the coverage change was applicable to all policyholders.

In her arguments, Ms. Boast said that the application of U.S. antitrust law to British defendants would conflict with the United Kingdom's right to protect its own regulatory scheme. The London market, she warned, "could grind to a halt."

In his presentation, Senior Deputy Solicitor General Wallace alleged that an "enforcement mechanism" involving both primary insurers and reinsurers created a boycott.

In addressing Ms. Boast's arguments, he said: "Comity is not an invitation to other nations to decide which of our laws they like or dislike."

Mr. Price also argued that the defendants had engaged in a boycott activity. Voluntary cooperation among insurers and reinsurers is permitted, he said, but "not cooperation induced with the heavy club of coercion."

Most of the exchanges between the attorneys and the justices concerned the boycott issue. At one point, for instance, Justice Stevens closely questioned Mr. Shapiro about whether an absence of available reinsurance indicated a refusal by reinsurers to deal and, thus, constituted a boycott.

"That's a remarkable accomplishment," said Mr. Lee, who is now president of Brigham Young University.

Despite his vast Supreme Court experience, Mr. Wallace is far from nonchalant. "Each case presents its own challenges," he said. "You must never take a case for granted. There is always a lot to say on both sides."

Mr. Lee also had high praise for Mr. Wallace personally. "Larry is very smart, very intelligent," as well as very knowledgeable about the law in general and Supreme Court law in particular. "As an advocate, he's not what you would

call charismatic or dynamic." But often those who are a bit understated can be the most effective, he said.

No one in the solicitor general's office is indispensable, said Mr. Lee, but Mr. Wallace comes as close as possible. Referring to his 25 years of service under seven presidents, Mr. Lee called him the "institutional memory" of the office.

Mr. Wallace, who says his age is "classified," is described as being in his early 60s. He is a Columbia Law School graduate and clerked for U.S. Supreme Court Justice Hugo Black. **B1**

Mr. Shapiro responded that it did not. The reinsurers were "simply agreeing" on acceptable terms of coverage, he said, explaining that there was no absolute refusal to deal. Reinsurers were willing to write the coverage as long as it included proper terms.

McCarran-Ferguson is unique, Mr. Shapiro pointed out, because it leaves to the states to decide which agreements among insurers are prohibited.

Justice Scalia then asked Mr. Shapiro why insurers would be concerned about which risks reinsurers will accept.

The reason is solvency, responded Mr. Shapiro. If reinsurers are writing coverages that have great exposure, the reinsurers' problems become a risk to the primary insurer as well.

"I see," said Justice Scalia. One observer subsequently remarked that a light bulb appeared to flash above the justice's head.

Shortly afterwards, Justice Scalia commented that the notion that reinsurers could be coerced by insurers is laughable on its face. "You're going to boycott Lloyd's of London?" he asked.

Mr. Shapiro responded by noting that the primary insurance company defendants had a minuscule piece of the market, which is "very telling."

Later, in questioning Mr. Wallace, Justice Scalia said there is no allegation that the reinsurers were coerced by the primary insurers. The primary insurers told reinsurers that if they provided coverage, "we'll all go down" together, he said. "Why is that an evil?"

Mr. Wallace said the claim could be made that insurers were trying to gain a competitive advantage and were trying to prevent other insurers from competing on terms their customers might prefer.

Justice Kennedy then asked whether reinsurers would have been engaged in a boycott if they had decided to limit coverage on their own.

The answer "gets complicated," responded Mr. Wallace. Certainly, reinsurers could have agreed on what types of coverage would be offered and not have engaged in a boycott, he said.

But on the other extreme, if an enforcement mechanism was in place so that someone who broke ranks was penalized, "that would in our view be a boycott," said Mr. Wallace.

But, he again agreed that if reinsurers acted on their own, it "arguably would not" be a boycott.

Justice Kennedy then asked why this scenario could be classified as a boycott with the involvement of primary insurers.

"It's the enforcement mechanism that has made this a boycott" because it prevents competitors of the primary insurer defendants from offering certain products, Mr. Wallace replied. There would not have been that kind of market discipline if only reinsurers had been involved, he said.

At another point, Mr. Price told the court the reinsurers had joined together with the insurers for the purpose of assuming less risk and more profit.

"Someone had to talk them into that?" asked Justice Scalia, whose remark was greeted with laughter in the courtroom.

The justice added that all the insurers had to do was to explain the situation and reinsurers would have said, "By golly, you're right."

The arguments were heard not only by the justices, but by row upon row of somberly clad attorneys, including many for individual defendants and others with an interest in antitrust law.

The spectators included Judge William Schwarzer, whose 1989 summary judgment dismissal of the suit was overturned by the 9th Circuit. Judge Schwarzer now serves as director of the Federal Judicial Center in Washington.

Ms. Boast said Judge Schwarzer congratulated her after the hearing on a job well done. **B1**



Mr. Price

Sedgwick's profits decline

By STACY SHAPIRO

LONDON—Sedgwick Group P.L.C.'s decision to value its real estate assets on a historical cost basis for 1992 has sharply lowered the value of its shareholders' equity.

Analysts expressed concern about the 37% drop in the value of Sedgwick's real estate assets caused by the accounting change, which caused shareholders' equity to slip 32%.

A 29% decline in 1992 pretax profits to 58.2 million pounds (\$87.9 million at year end) and a slight 1% gain in gross revenues to 631.9 million pounds (\$954.2 million) corresponded with analysts' forecasts.

The accounting change lowers the

value of the company's real estate holdings to 150.6 million pounds (\$228.2 million), compared with their reported value in 1991 of 239.4 million pounds (\$362.7 million), which was based on a 1988 valuation. After recognizing a 13.8 million pound (\$20.9 million) tax benefit, the accounting change reduced Sedgwick's shareholders' equity by 73.2 million pounds (\$110.9 million) to 152.4 million pounds (\$230.9 million).

The U.K. property market has nosedived since 1988, so it was "prudent" to adjust the value of the properties to historical cost, Sedgwick Finance Director Stuart Tarrant said.

However, some analysts suggested the current value of the properties

may actually be lower than the historical values, given the depressed real estate market.

A key ratio for brokers is whether they have enough cash to cover their liabilities to underwriters and clients, said one London analyst. "Sedgwick does—just," he said.

After the readjustment of property values, Sedgwick has year-end 1992 assets totaling 2.39 billion pounds (\$3.62 billion) and liabilities of 2.23 billion pounds (\$3.38 billion).

Texas to restrict liability lawsuits

AUSTIN, Texas—Two bills restricting product liability and other lawsuits against corporations have been passed by the Texas Legislature.

Gov. Ann Richards is expected to sign both bills.

S.B. 4, passed Wednesday, would restrict product liability suits against the makers of tobacco, liquor and other "inherently dangerous" products. It would also require manufacturers to indemnify retailers for damage awards in cases in which the retailers did not alter the products. A section limiting liability for vaccine makers was removed before passage.

S.B. 2, passed last Monday, would give Texas judges more discretion to dismiss personal injury and wrongful death suits against corporations that do business in Texas but were brought by foreigners injured in their own countries.

—By Nancy Johnson

Coal company to pay fines

LOUISVILLE, Ky.—A British-owned coal company will pay \$3.75 million in fines for safety rule violations in connection with the 1989 methane gas explosion that killed 10 workers.

Costain Coal Inc. was indicted late last month by a federal grand jury in Louisville on 32 violations of the Mine Safety Act. The company pleaded guilty to 29 violations and no contest to three.

The explosion occurred at the William Station Mine, which was operated at the time by Pyro Mining Co., a company that Costain later acquired.

The indictment charged that Pyro's hazardous practices could have contributed to the fatal explosion and that the unsafe working conditions were frequently concealed from federal inspectors responsible for enforcing the Mine Safety Act.

The guilty pleas came shortly after James H. Tichenor, who was the mine's acting foreman, pleaded guilty to charges of falsifying records of methane levels nearly two months before the explosion.

Further individual investigations are being conducted in connection with the explosion, according to U.S. Attorney Joseph Whittle.

—By Sally Roberts

Clausen promoted at Sony Pictures

Janel Clausen has been named vp-risk management at Sony Pictures Entertainment in Culver City, Calif. Ms. Clausen reports to Joseph W. Kraft, vp and treasurer. In this new position, Ms. Clausen is responsible for all risk management functions, including insurance placement and coordination of the corporate loss control and safety program. Ms. Clausen joined what is now Sony in 1984 as an insurance administrator-West Coast for Columbia Pictures. She was named corporate director of risk management in 1987 and was promoted to assistant treasurer-risk management in 1991. Prior to joining the company she was assistant manager-risk management and insurance for MCA Inc., a producer, distributor and marketer of entertainment-related products and services. Ms. Clausen is a deputy member of the Risk & Insurance Management Society Inc. and also holds the Associate in Risk Management designation.

Gregory F. "Red" Hidden, 44, has joined American General Hospitality Inc. as director of risk and insurance services. In this newly created position, Mr. Hidden is responsible for developing and managing risk and insurance programs for the Dallas-based hotel management and consulting firm. His responsibility also includes industrial and environmental health and safety programs for more than 60 hotels the firm manages nationwide. Mr. Hidden, who reports to President Steven D. Jorns, previously was managing director of The Hidden Group Ltd., a risk management and loss control consulting service in Riverside, Calif., and Longmont, Colo. Mr.

Comings & goings: Buyers

Hidden also serves as national risk management services coordinator for USA Hockey Inc., the national Olympic governing body for ice hockey. He holds a bachelor's degree in criminal justice from San Diego State University and a master's degree in business administration, specializing in strategic management, from National University in San Diego. He also holds the Associate in Risk Management designation; is a deputy member of RIMS; and is a member of the Public Risk Management Assn., the American Society of Safety Engineers and the American Society for Training & Development.

Bruce A. Cadwallender, 43, has been named risk manager at Tendercare (Michigan) Inc., a provider of long-term health care services based in Sault Sainte Marie, Mich. In this newly created position, he is responsible for property/casualty insurance, claims management and risk management. He also will oversee the development of risk financing options, litigation management, and occupational safety and health programs. He reports to George K. Herron, director of human resources. Mr. Cadwallender joined Tendercare in 1991 as loss control manager. Prior to joining the firm, he spent nine years at Alexander & Alexander Inc., most recently as vp and marketing manager for the National Public Entity Division in Atlanta. Previously, he was a loss control specialist at INA Loss Control Services Inc. in Cleveland. Mr. Cadwallender earned a bachelor's degree in

systems science from Michigan State University in East Lansing and a master's degree in safety from Central Missouri State University in Warrensburg. He is a professional member of the Society of Safety Engineers and holds the Certified Safety Professional and Certified Product Safety Manager designations.

Connie Rank has been named assistant vp-human resources at Jewelers Mutual Insurance Co. in Neenah, Wis. Ms. Rank, who reports to President Ronald Harder, heads the human resources department, including benefit administration, personnel policy development and employee recruitment. Ms. Rank joined the company in April as director of human resources. Prior to that, she was director of human resources for the West Side Clinic in Green Bay, Wis., and the LaSalle Clinic in Neenah. Among her professional affiliations, she serves on the board of the Wisconsin chapter of the National Society for Human Resource Management and on the national human resources committee for the Conference of Casualty Insurance Cos. She also is a member of the Wisconsin Insurance Personnel Directors Assn.

We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Contact Roseanne White, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590; 312-649-7785. Please send a photograph, too.

Update

Court bars medical product suit

Continued from page 2

decision that Jennifer Stamps could not sue Collagen Corp. for the defective design of Zyderm, a collagen cosmetic "device" that is injected under the skin to correct wrinkles and skin deformities. Ms. Stamps allegedly developed an autoimmune disease from the product, which is still on the market.

The court found that the FDA's initial approval of the product in 1981 precludes lawsuits seeking damages.

It is unlikely that breast implants, also considered a medical device, will fall under the scope of the decision, attorneys say.

While collagen underwent FDA premarket review after the agency was given jurisdiction over medical devices in 1976, breast implants had been on the market for several years and were never officially approved, said Joe Radden, an attorney with Beck, Radden & Secrest in Houston who represented Collagen Corp. in the Stamps case.

Health reform funding proposal

WASHINGTON—President Clinton last week laid out the possibility that the administration will propose boosting cigarette taxes to help fund universal health care coverage.

A higher cigarette tax levy may be appropriate, Mr. Clinton said after a meeting with business executives, because "we are spending a ton of money in private insurance and in government tax payments to deal with the health care problems occasioned by bad health habits, and particularly smoking."

Meanwhile, a White House spokeswoman denied a published report that the administration's Task Force on National Health Care Reform has decided against a tax on health care benefits to fund expanded health care access. She said no final decisions have been made.

Ohio governor threatens veto

COLUMBUS, Ohio—Gov. George Voinovich said he will veto a proposed budget for Ohio's Bureau of Workers' Compensation unless the state Legislature revives budgetary performance standards and passes a stricter workers comp reform proposal.

A proposed \$629 million 1994-1995 budget for the bureau, which manages the state's exclusive fund, should continue to include standards that help legislators measure the bureau's claims processing effectiveness, the governor wrote in a letter to Rep. Patrick Sweeney, D-Cleveland, who chairs the Ohio House's Finance and Appropriations Committee.

In addition, a workers comp reform proposal, which has been discussed for months though not introduced, needs stronger managed care techniques to trim "soaring" medical costs, Gov. Voinovich said. Also, workers comp benefits should be coordinated with other benefits as a return-to-work incentive.

Hoechst suing IRM, adjuster

DALLAS—Hoechst Celanese Corp. is suing its Bermuda captive manager and a loss adjuster, alleging the claims payment it received after the 1987 explosion of its Pampa, Texas, plant was inadequate.

In a suit filed Jan. 29 in Texas State Court in Dallas, Hoechst is seeking \$100 million from IRM Group Ltd.; its Bermuda subsidiary, IRM (Bermuda) Ltd.; IRM's U.S. affiliate, American Risk Management Inc.; loss adjuster GAB Services Inc.; and MK-Ferguson Co., an engineer hired by GAB to help adjust the claim.

Hoechst has received about \$507 million in payments from its captive, Elwood Insurance Ltd., and from Hopewell International Insurance Ltd., a pool that reinsured Elwood. However, Hoechst now alleges that IRM, which manages Elwood and Hopewell, and GAB mismanaged the settlement.

In 1991, Hoechst estimated it sustained \$599 million in property losses from the blast (BI, May 13, 1991).

The suit alleges that the defendants' mismanagement resulted in the "gross undercalculation of the claim and extensive delays in the adjustment, leading to increases in costs and injury to Hoechst's name and reputation in the marketplace."

IRM officials declined to offer detailed comments on the suit, but said they believed the original settlement was fair. "These allegations are unfounded and a vigorous defense will be mounted," said Art Deters, IRM's chief executive officer.

Briefly noted

British Gas P.L.C. has terrorism coverage for a plant in Warrington, England, where three bombs exploded last Friday. One natural gas storage container was destroyed and another caught fire. . . . The California Supreme Court denied a petition by National Union Fire Insurance Co. of Pittsburgh, Pa., for review of an appeals court decision that the insurer acted in bad faith in canceling a policy issued to officers of now-insolvent Technical Equities Corp. (BI, Nov. 9, 1992). . . . Continental Corp. is withdrawing from underwriting in Japan and is transferring about 2.18 billion yen (\$18.6 million) in non-life insurance business to Assicurazioni Generali S.p.A. of Italy. . . . A federal jury ordered Lloyd's of London syndicates to pay \$7 million to the Seattle Seahawks under disability insurance policies after it ruled that an on-field injury ended the career of former linebacker Brian Bosworth. . . . The National Council on Compensation Insurance is seeking a 27.7% workers comp rate increase in Oklahoma's voluntary market. If the rate hike is approved, premiums would jump to \$434 million, the NCCI says. . . . Joseph W. Duva last week joined Preferred Solutions Inc., which designs and administers prescription drug programs, as chairman and chief executive officer. Mr. Duva previously was a partner with Ernst & Young. Earlier, he was director of employee benefits at Allied-Signal Inc.

HMO stocks

Continued from page 3

"Their largest player—Kaiser Foundation Health Plan Inc.—had a rate reduction that was really just a cost-shift to beneficiaries of an increased copayment," he said.

"If that factor were removed, they may have had a higher rate increase," he said.

However, only \$42 million of the \$95 million that CalPERS estimates it saved in 1993 was due to benefits standardization, according to Rob Campbell, a CalPERS' health policy analyst.

"We have no data that our rate negotiations triggered any managed care stock devaluations," he said.

Unfortunately for the already-battered HMO stocks, CalPERS' announcement "was followed by Clinton's pre-announcement of his State of the Union address in which he mentioned health care," noted Alex. Brown's Ms. Kerns.

"I get the sense that people are afraid that Bill and Hillary are going to reform the health care system all by themselves," she quipped.

Gloria Vogel, an analyst with Lehman Bros. in New York, agreed: "It was the Hillary factor."

Todd Richter, senior vp-health services with Dean Witter Reynolds in New York,

said that health reform trial balloons sent up by the Clinton administration have frightened away institutional investors.

"But stocks have rebounded sharply in the last few days," he said.

"We got caught in a market nervousness," said a spokesman for Woodland Hills, Calif.-based Wellpoint Health Networks Inc., a for-profit HMO recently spun off from Blue Cross of California.

Wellpoint, which opened at \$28 a share on its first day of trading Feb. 3, closed at \$24 a share on Feb. 22, before rising to \$27.25 on Feb. 25.

"But we went up \$10 and down \$10 during what was supposed to be a quiet period," the spokesman said.

Following the president's 10-minute televised speech on Feb. 14, PacificCare's series-A stock dove to \$40.50 a share from a high of \$57.50 on Feb. 8.

It fell again to \$34 per share on Feb. 18, the day after the State of the Union address during which the freeze on Medicare payments was proposed, and dropped to \$26 on Feb. 22.

It was up to \$35.50 on Feb. 25.

Some investment analysts speculate that PacificCare's large Medicare enrollment may have scared investors.

But that doesn't explain TakeCare Corp.'s plunge to \$27 per share on Feb. 22 from \$48.25 on Feb. 3.

By Feb. 25, it had rebounded only to \$28.88.

"We have no Medicare enrollment yet," explained Chris Ohman, director of investment relations for the Concord, Calif.-based HMO.

Investors' reaction to this chain of events is "counter-intuitive" he said. "They really don't get it."

Even if TakeCare did cover Medicare beneficiaries, President Clinton's suggestion that Medicare payments be frozen won't affect HMOs' bottom lines, he asserted.

"What we bring to the Medicare market is a fundamental shift in the utilization mix," with greater emphasis on early intervention and preventive care that reduces overall health care costs.

Currently, less than 5% of the nation's 33 million Medicare beneficiaries are enrolled in HMOs.

"We're scratching our heads a little bit," said a spokesman for Los Angeles-based Maxicare Health Plans Inc., shares of which fell to \$9 on Feb. 22 from \$13.75 on Feb. 3.

They had climbed to only \$9.75 on Feb. 25.

"We feel that the ultimate solution (to skyrocketing health care costs) lies with us," he said, referring to the overall managed care industry.

While most HMO analysts believe that once investors are educated about how HMOs operate they'll start re-investing, they are likely to be more discriminating next time.

"Now you'll see the investors sort out some of the players and start identifying the best of the HMO stocks," predicts TakeCare's HMO.

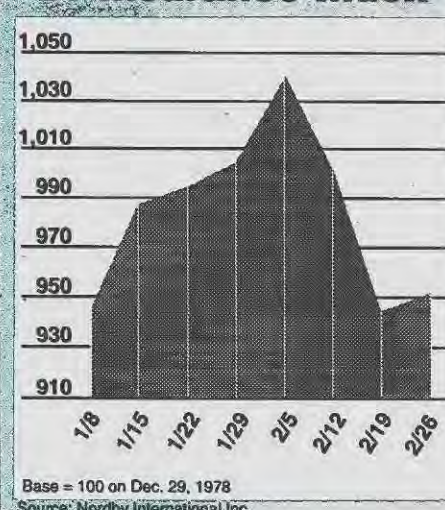
Such a move would likely accelerate a shakeout that has been occurring in the HMO marketplace for a number of years.

During the last year, there were at least half a dozen major mergers and acquisitions.

One example was Foundation's acquisition last year of Century MediCorp. of Los Angeles.

"To the extent that we've had a lot of cleansing, you're most likely to see (investors) move first into the companies in which people have the most confidence, which could make some companies more vulnerable to takeover," observed Foundation's Mr. Davis.

BI Insurance Index



Insurance industry stocks rose last week, as the *Business Insurance Index* climbed 4.8 points to 951.0 on Feb. 26 from 946.2 on Feb. 19. Advancing issues for the week were led by PacificCare Health Sys., up 19.7%; Phoenix RE Corp., up 10.2%; and Allied Group Inc., up 9.4%. Declining issues for the week followed Safeguard Health Enter., down 16.2%; Chandler Insurance, down 5.6%; and Argonaut Group, down 5.3%. The most active issue was U.S. Healthcare, 17.1 million shares traded. The *BI Index* was up 0.5%; the NYSE Composite was up 2.0%; the Standard & Poor's 500 was up 2.1%; and the Dow Jones 30 Industrials rose 1.5%.

British Issues

Feb. 25	Price	P/E	Div.	Yield	1 Week
Companies	pence		pence	%	High-Low
Comml Union	586	NM	32.5	5.5	586-573
Genl Accident	559	NM	35.7	6.4	585-559
Gdn Royal Exch	186	NM	10.0	5.4	186-178
Royal	285	NM	6.7	2.4	288-285
Sun Alliance	316	NM	19.0	6.0	319-316
Brokers					
Bradstock	143	16.9	6.8	4.8	144-143
CE Heath	360	20.8	21.3	5.9	360-347
Hogg Group	185	17.7	10.9	5.9	188-185
JIB Group	185	14.1	10.0	5.4	186-185
Lloyd Thompson	279	22.5	7.5	2.7	279-270
Lowndes Lmbt	352	13.9	16.8	4.8	355-352
PWS Holdings	59	8.8	5.3	9.0	59-59
Sedgwick Grp	160	19.3	8.0	5.0	170-160
Steel Brl Jones	237	11.5	17.7	7.5	237-237
Willis Corroon	178	11.4	17.6	9.9	178-173

Source: Philip Olsen, London * Estimated

P/C stocks also take a tumble

Health maintenance organization stocks aren't the only insurance stocks battered over the past two weeks: Property/casualty stocks also took a tumble.

"When they get nervous about the state of the economy, (investors) just dump insurance stocks," said Gloria Vogel of Lehman Bros. in New York. "Many investors are unsure of the economic outlook because of Clinton's recent tax proposals."

Property/casualty stocks fell again early last week after a story in Monday's Wall Street Journal noted commercial liability insurance rates still are not rising.

However, property/casualty stocks rallied late last week after American

International Group Inc. announced its net income rose 7% in 1992 to \$1.66 billion despite last year's catastrophes.

For example, AIG closed at \$120 per share on Thursday, a sharp turnaround from \$112.88 on Monday. AIG finished the previous week on Feb. 19 at \$117.25, compared with \$123 on Feb. 12, before President Clinton's two speeches on the economy.

Among other property/casualty issues, Chubb Corp. closed at \$90.88 Thursday, up from \$85.88 on Monday. Chubb stood at \$89 on Feb. 19 and \$92.25 on Feb. 12.

General Re Corp. closed at \$117.25 on Thursday, up from \$112.13 on Monday. It had closed at \$117.50 on Feb. 19, down from \$122 on Feb. 12.

BI Industry Stock Report

FEBRUARY 22, 1993 THROUGH FEBRUARY 26, 1993

BROKERS																									
	Price	Weekly % change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value		Price	Weekly % change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value		
Accordia Inc.	NYS	21.13	1.81	-1.74	24.75	15.13	93	0.36	1.70	18	7.01	3.01	Mutual Risk Mgmt. Ltd.	NYS	39.75	0.63	-1.85	46.00	25.75	90	0.28	0.70	23	7.51	5.29
Alexander & Alexander	NYS	26.13	0.00	-1.42	28.88	18.00	378	1.00	3.83	19	10.00	2.61	NAC Re Corp.	OTC	41.00	-2.96	1.23	44.75	21.75	259	0.16	0.39	72	13.60	3.01
Gallagher Arthur J. & Co.	NYS	33.50	-0.37	18.58	35.00	21.00	173	0.64	1.91	21	6.35	5.28	National Re Corp.	NYS	35.38	-2.08	19.41	39.00	17.00	162	0.12	0.34	20	N/A	N/A
Hill, Rogal & Hamilton	NYS	16.13	3.20	3.20	16.38	11.00	67	0.44	2.73	23	3.11	5.18	Navigators Group	OTC	32.00	5.35	-1.54	48.00	28.50	12	0.00	0.00	23	15.69	2.04
Marsh & McLennan	NYS	94.75	3.98	3.69	97.63	71.25	541	2.68	2.83	22	14.40	6.58	Nobel Insurance LTD.	OTC	7.50	3.45	27.66	8.25	4.25	263	0.00	0.00	5	3.91	1.92
Poe & Associates	OTC	16.88	2.27	0.75	19.00	11.25	1	0.40	2.37	21	2.64	6.39	NWNL Companies	NYS	59.63	5.53	17.20	62.13	29.75	250	1.48	2.48	14	46.21	1.29
BROKERS	AVERAGE	1.8	3.8					2.2	18				Ohio Casualty Corp.	OTC	65.63	-2.42	3.96	68.75	49.00	189	2.84	4.33	12	43.08	1.52
CONGLOMERATES & HOLDING COMPANIES																									
Berkley W.R. Corp.	OTC	46.88	-4.34	9.01	50.50	31.00	1272	0.36	0.77	17	23.51	1.99	Old Republic Int'l	NYS	24.63	-1.99	-1.01	27.38	18.75	671	0.40	1.62	8	18.63	1.32
Berkshire Hathaway Inc.	NYS	12475.0	2.67	6.17	12850.0	8675.00	0	0.00	0.00	50	6437.25	1.94	Orion Capital Corp.	NYS	39.38	2.61	11.31	41.25	23.19	64	0.80	2.03	8	28.62	1.38
ITT (Hartford Group)	NYS	75.63	1.17	5.03	76.25	62.50	1279	1.96	2.59	-29	68.23	1.11	Phoenix RE Corp.	OTC	25.75	10.16	63.49	25.75	8.88	2680	0.20	0.78	-40	13.32	1.93
Sears (Allstate)	NYS	53.00	-0.93	16.48	54.75	37.75	6710	1.60	3.02	-9	40.18	1.32	Provident Life	NYS	28.88	1.32	1.32	31.50	20.00	155	1.04	3.60	12	30.38	0.95
CONGLOMERATES	AVERAGE	-0.4	9.2					1.6	7				Re Capital Corp.	ASE	15.50	-2.36	-6.06	16.63	12.25	8	0.24	1.55	74	16.88	0.92
INSURERS/REINSURERS																									
AEGON N.V.	NYS	46.38	1.09	11.41	46.38	33.00	38	0.68	1.47	8	34.06	1.36	Reliance Group Holdings	NYS	6.13	2.08	0.00	7.13	4.00	196	0.32	5.22	3	2.94	2.08
Aetna Life & Casualty	NYS	49.25	7.36	5.91	53.75	38.00	1865	2.76	5.60	90	67.08	0.73	RLI Corp.	NYS	28.00	0.00	13.13	28.63	17.75	17	0.52	1.86	12	17.92	1.56
Allied Group Inc.	OTC	40.75	9.40	28.35	40.75	18.75	444	0.64	1.57	12	11.29	3.61	St. Paul Companies	NYS	77.63	-2.51	0.81	83.25	66.50	968	2.80	3.61	-13	59.79	1.30
Allmerica Prop. & Casualty	OTC	55.75	4.69	10.40	55.75	34.75	69	0.44	0.79	9	40.44	1.38	SAFECO Corp.	OTC	63.25	4.12	11.45	64.50	42.00	1030	1.64	2.59	15	35.37	1.79
American General	NYS	58.63	3.30	2.85	61.50	40.25	1021	2.20	3.75	12	39.89	1.47	SCOR U.S. Corp.	NYS	20.00	-1.23	14.29	20.63	13.13	7	0.28	1.40	83	14.39	1.39
American Heritage Life Ins.	NYS	31.88	-1.54	5.37	33.88	24.88	11	0.84	2.64	15	16.51	1.93	Seibels Bruce Group	OTC	1.88	3.42	0.00	6.13	0.38	113	0.00	0.00	0	6.22	0.30
American Indemnity/Fin'l	OTC	8.75	-4.11	45.83	9.75	4.75	8	0.08	0.91	5	14.43	0.61	Selective Ins. Group	OTC	24.00	-3.03	9.09	25.75	16.75	48	1.12	4.67	12	20.22	1.19
American International	NYS	122.13	4.16	5.28	127.88	82.00	3154	0.56	0.46	16	54.21	2.25	Statesman Group Inc.	OTC	14.00	4.67	16.67	14.88	5.00	861	0.05	0.36	8	6.71	2.09
Aon Corp.	NYS	51.25	0.74	-5.09	55.50	39.75	410	1.68	3.28	17	27.17	1.89	Tokio Marine & Fire	OTC	47.63	-0.26	-0.78	52.63	32.25	5	0.00	0.00	95	70.93	0.67
Argonaut Group	OTC	29.13	-5.28	-4.51	33.25	25.50	178	0.84	2.88	9	21.70	1.34	Torchmark Corp.	NYS	69.25	-0.41	6.17	64.75	36.00	993	1.04	1.73	17	14.87	4.05
AVEMCO Corp.	NYS	24.75	-1.00	5.88	28.00	21.00	21	0.40	1.62	30	7.33	3.38	Transamerica	NYS	48.25	-0.26	0.52	51.00	40.00	779	2.00	4.15	11	35.86	1.35
Baldwin & Lyons Inc.	OTC	33.63	0.00	-7.88	36.50	26.50	0	0.48	1.43	8	30.85	1.09	Transatlantic Holdings	NYS	53.00	-0.47	-5.57	56.75	29.38	284	0.28	0.53	18	21.85	2.43
Chandler Insurance	OTC	4.25	-5.56	-10.53	7.63	3.88	1	0.00	0.00	19	8.63	0.49	Travelers Corp.	NYS	26.75	3.38	-1.83	30.75	17.13	1455	1.80	5.98	-3	43.85	0.61
Chubb Corp.	NYS	91.38	2.67	2.81	95.50	62.38	1494	1.60	1.75	13	40.67	2.25	Travelers Group Inc.	OTC	45.00	2.86	10.43	47.75	25.00	166	0.80	1.78	18	23.87	1.89
CIGNA Corp.	NYS	61.63	0.00	5.12	68.00	47.13	1462	3.04	4.93	11	81.73	0.75	United Fire & Casualty	OTC	40.00	-2.44	-3.61	43.00	35.34	0	1.00	2.50	17	28.47	1.40
CNA Financial Corp.	NYS	93.75	3.02	-4.34	102.88	78.50	115	0.00	0.00	-9	80.24	1.17	Unifair	OTC	42.00	0.60	-1.75	44.00	32.75	168	1.20	2.86	13	36.51	1.15
Continental Corp.	NYS	26.38	-1.86	-1.86	34.75	20.00	1089	1.00	3.79	12	38.32	0.69	UNUM Corp.	NYS	53.75	2.38	1.42	58.00	32.00	1244	0.64	1.19	15	21.83	2.46
EXEL Ltd.	NYS	44.75	0.56	-5.29	51.00	32.13	811	1.00	2.23	9	N/A	N/A	US Facilities Corp.	OTC	8.38	1.52	-16.25	17.75	7.00	182	0.00	0.00	8	9.64	0.67
Fund American Corp.	NYS	74.25	1.71	3.13	74.50	62.50	34	0.00	0.00	54	81.85	0.91	USF&G Corp.	NYS	13.75	-1.79	11.11	15.00	8.00	1426	0.20	1.45	-81	10.29	1.34
Framont General Corp.	OTC	38.75	1.97	12.32	38.75	17.00	179	1.08	2.79	9	25.62	1.51	USLICCO Corp.	NYS	16.13	-2.27	-10.42	20.00	15.00	34	0.24	1.49	23	29.80	0.54
Frontier Insurance Group	OTC	44.25	2.02	1.72	46.25	27.03	44	0.60	1.36	15	13.97	3.17	USLIFF Corp.	NYS	40.25	3.87	11.03	42.63	28.41	711	1.20	2.98	13	64.90	0.62
Gainco Inc.	ASE	18.38	7.30	30.09	19.50	7.78	176	0.04	0.22	25	2.65	6.93	Washington National	NYS	25.88	5.61	12.50	27.50	16.63	112	1.08	4.17	15	30.27	0.85
General RE Corp.	NYS	117.13	-0.32	1.19	130.50	77.50	1849	1.88	1.61	17	46.07	2.54	Zenith National Ins.	NYS	25.50	4.08	29.11	25.50	14.50	48	1.00	3.92	27	14.81	1.72
Guaranty National Corp.	NYS	20.63	3.13	4.43	23.00	13.50	88	0.48	2.33	13	9.12	2.26	INSURERS/REINSURERS	AVERAGE	1.2	5.9					2.5	18.4			
Hartleysville Group	OTC	27.00	-4.42	-4.42	32.75	17.75	92	0.64	2.37	11	16.77	1.61	FHP International	OTC	20.88	-1.18	4.38	29.00	12.50	2954	0.00	0.00	19	9.61	2.17
Hartford Steam Boiler	NYS	58.38	5.18	1.08	59.25	45.13	81	2.12	3.63	21	19.74	2.96	Pacificare Health Sys.	OTC	36.50	19.67	-28.43	57.50	25.25	1363	0.00	0.00	19	3.90	9.36
Kemper Corp.	NYS	29.00	2.20	-2.11	35.25	20.75	1186	0.92	3.17	-8	37.66	0.77	Safeguard Health Enter.	OTC	7.75	-16.22	-20.51	14.75	7.00	40	0.00	0.00	9	4.03	1.92
Lawrence Insurance Group	ASE	7.75	-1.59	-10.14	10.25	7.00	2	0.48	6.19	18	4.66	1.66	Sierra Health Services	ASE	14.63	3.54	-32.37	21.69	8.06	331	0.00	0.00	13	2.01	7.28
Liberty Corp.	NYS	29.63	-0.84	4.87	32.88	22.25	35	0.56	1.89	12	18.43	1.61	United Healthcare Corp.	NYS	44.13	-4.59	-22.42	68.00	34.25	6187	0.03	0.07	27	4.68	9.43
Lincoln National	NYS	73.25	1.21	0.17	78.25	50.50	1051	3.04	4.15	9	58.92	1.24	United Medical Corp.	ASE	9.13	0.00	43.14	9.75	6.13	2	0.20	2.19	22	10.30	0.89
Markel Corp.	OTC	35.50	0.00	13.60	36.00	23.00	32	0.00	0.00	8	15.44	2.30	U.S. Healthcare	OTC	42.00	-3.45	-5.88	59.75	29.00	17076	0.52	1.24	23	3.60	11.67
													HEALTH MAINTENANCE ORGANIZATIONS												



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